R.N.

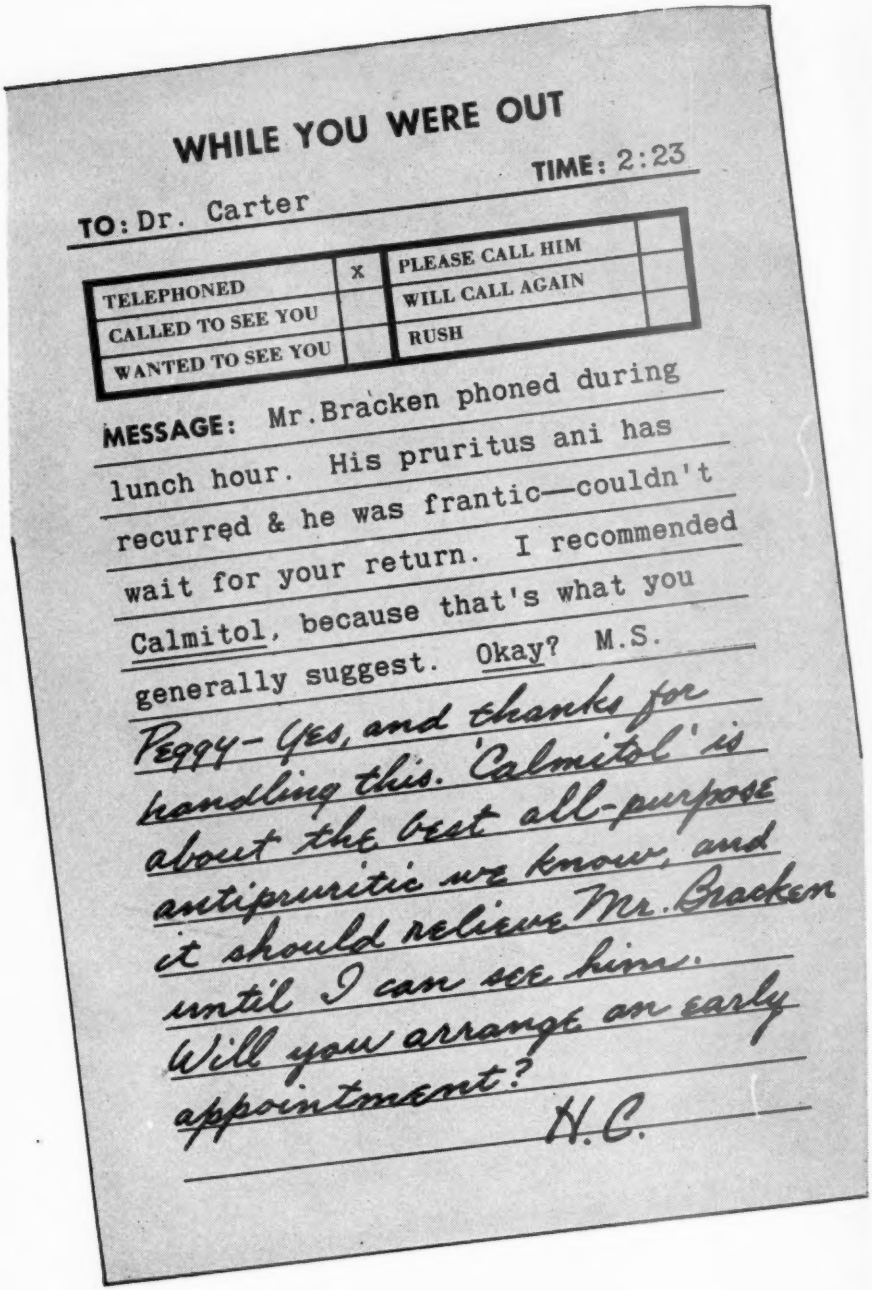
A JOURNAL FOR NURSES

Disaster Symposium

Muscle Metabolism

Miss Nightingale's Personality

May 1956



WHILE YOU WERE OUT

TIME: 2:23

TO: Dr. Carter

TELEPHONED	X	PLEASE CALL HIM	
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTED TO SEE YOU		RUSH	

MESSAGE: Mr. Bracken phoned during lunch hour. His pruritus ani has recurred & he was frantic—couldn't wait for your return. I recommended Calmitol, because that's what you generally suggest. Okay? M.S.

Peggy – Yes, and thanks for handling this. 'Calmitol' is about the best all-purpose antipruritic we know, and it should relieve Mr. Bracken until I can see him. Will you arrange an early appointment?

H.C.

*CALMITOL is the non-sensitizing antipruritic supplied in 1½-oz. tubes and 1-lb. jars by THOS. LEEMING & CO., INC., 155 East 44th St., New York 17, N. Y.

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A JOURNAL R.N. FOR NURSES

VOLUME XIX • NUMBER V • MAY 1956

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BPA NBP

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FOUNDED in 1883, Northwestern Hospital School of Nursing in Minneapolis, Minn., has the distinction of being the oldest nursing school in the state. Progressing from a one-year course to a three-year course in 1901, it now offers a three-year basic diploma program. It is affiliated with Abbott and St. Barnabas Hospitals Schools of Nursing in a centralized planning and teaching program coordinated by the director of the nursing education department at Macalester College in St. Paul.

Preclinical courses are taught through affiliation with Macalester, and Northwestern graduates may enroll in the college's program leading to a B.S. degree.

One of the school's honored traditions is the awarding of a black velvet cuff band to students after successful completion of their second year.

The school's gold star pin was designed by a Northwestern graduate. Each of its points represents an ideal for nurses to follow. One signifies spiritual growth; another, personal growth; a third, scholastic advancement; a fourth, positive health; and the last, sensitivity to the needs of others.

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CIGARETTE ADS

Dear Editor:

I've been a regular subscriber to R.N. since my graduation in '52, and I'm so grateful for this "monthly refresher course." One objection: Should cigarette advertising appear in a nursing magazine? How do other R.N.'s feel about this?

(Mrs.) FAY HILL, R.N.
HARTFORD, CONN.

[*Over the years, whenever* R.N. *has published a cigarette advertisement, a few of our readers have registered their disapproval. In all sincerity we, too, would appreciate your opinions on this type of advertising in a nursing journal.*—THE EDITORS]

"TODAY'S APPROACH"

Dear Editor:

Mrs. Neff's letter (R.N., Jan.) includes this statement: "I entered training with the knowledge that I was not cut out for nursing."

In my opinion, nursing should be reserved for women who are "cut out for," trained in, and dedicated to the bedside care of the ill. I'm not crying out for the good old days, but the world is crying out for good nurses. Hospitals are full of (a) willing but untrained practical nurses, and (b) highly specialized R.N.'s who feel that nursing care is beneath their dignity and who perform the duties of a secretary or personnel director while masquerading in the uniform of a nurse. Let's give this secretarial and personnel work back to the departments where it belongs and get back to the business of nursing.

BERNICE H. MCINTYRE, R.N.
HARVEY, ILL.

PRE-RETIREMENT

Dear Editor:

Your article, "A Retirement Home in the Making" (Sept. 1955 issue) encourages me to bring up a subject which concerns me closely. There must be many nurses, now around 60, who do not wish to live in a "home" but are anxious to make plans for retirement; those, for example, who have been in positions where it was not easy to develop enduring friendships; those who, because of their specialties, have done their too-engrossing work in widely separated parts of the country, and who now find themselves out of touch with former friends and without any new, congenial ones. Such nurses as I have in mind have some money and will receive maximum Social Security benefits. Before retiring, they would like to find a similarly-minded companion, and use the intervening years to build up a friendship and make preparations.

Perhaps a project is underway

somewhere to bring such nurses together. If so, I should like to know about it. Have any of R.N.'s readers heard of such a plan?

R.N., MADISON, WISC.

THEN AND NOW

Dear Editor:

I have read with great interest Helen Murphy Donovan's excellent article, "What's the Matter with Us?" in your Nov. 1955 issue. But I take exception to her statement that "Many of us are applying standards of a generation ago." I belong to that generation. I was trained by the late Anna C. Maxwell at the Presbyterian Hospital, New York City, and I assure you that she would turn in her grave if she could see most of the present-day nursing. "Your patient is your first consideration; never forget that, young ladies," she used to tell us. I can hear her now, bless her!

I am still nursing occasionally, and my heart sickens at the way some of today's nurses act. They are, as your author says, a detriment to our profession—and I hope that some change will soon be made in all training schools. It's sorely needed.

(Mrs.) FRANCIS L. BLEDSOE, R.N.

OPA LOCKA, FLA.

[*Mrs. Bledsoe is certainly right in maintaining that "Your patient is your first consideration." However, advances in medical science have brought a mechanization to nursing which we must strive to offset by the proper use of psychol-*

WHY PSORIASIS YIELDS TO RIASOL

The 25th edition of *The Dispensatory of the United States of America*[1], published late in 1955, reports that ammoniated mercury ointment has had great usefulness in initial treatment of psoriasis. Approximately 80% of ammoniated mercury is represented as metallic mercury (*Merck Index*[2]).

Since RIASOL contains 0.45% mercury chemically combined with soaps, its mercurial content is only 1/9th (11%) that of ammoniated mercury ointment (5%) U.S.P. XV[3]. This reduction explains why irritations and side effects rarely occur with the use of RIASOL.

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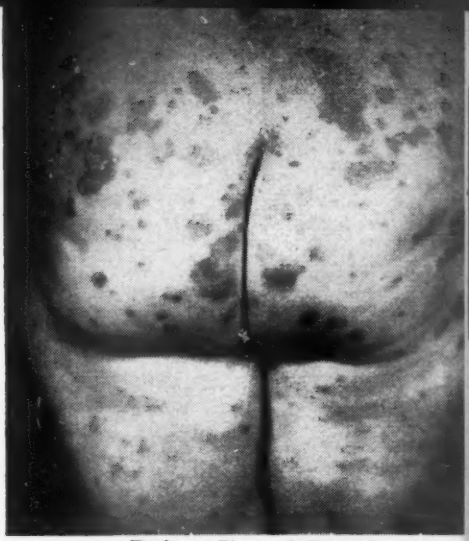
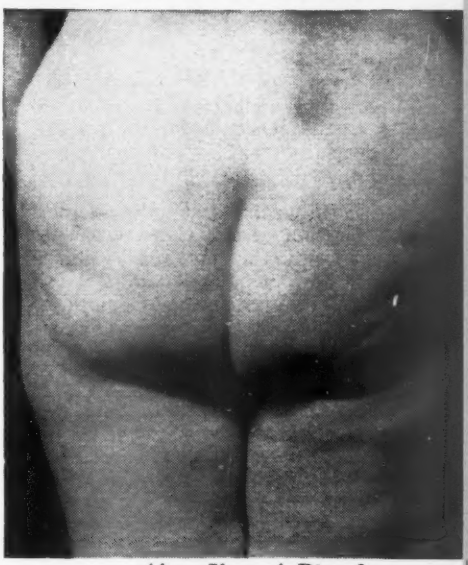
[1]*The Dispensatory of the United States of America*, 25th ed., 1955, p. 822.
[2]*Merck Index*, 6th ed., 1952, p. 612.
[3]*The United States Pharmacopoeia*, U.S.P. XV, 1955, p. 410.



Before Use of Riasol



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RIASOL FOR PSORIASIS

ogy and the social sciences. If we ever needed sympathetic, enlightened emotional support for patients, we need it now. I do not worry about our schools of nursing nearly so much as about the effect we graduate nurses have upon students who work with us during and after their educational period. They are strongly influenced by the kind of nursing care they see given.—HELEN MURPHY DONOVAN, R.N.]

"NO" WINS YESSES

Dear Editor:

Your January article, "What Every Nurse Should NO," by Marjorie Ann York, should be framed and posted in every nurses' station in every hospital. It's direct and wonderful. Having been a patient myself three times, I've run across every "NO" mentioned in the article, and have tried to correct such bad habits in my own work.

(Mrs.) DON ENGLESON, R.N.
HIBBING, MINN.

* * *

Dear Editor:

What a refreshing and well-written article! I hope Marjorie Ann York continues writing for R.N.

HELEN KING, R.N.
SAN FRANCISCO, CALIF.

* * *

Dear Editor:

My little white cap is off to Marjorie Ann York. Recently I was a maternity patient in a Washington, D.C., hospital, and I now realize how important all the simple phases of bedside care can be in

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Dihydrostreptomycin	14.2	25.9	12.5	38.7	27.2	28.0	6.6
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Oral Suspension, 5 mg. per cc., bottle of 118 cc.

REFERENCES: 1. Waisbren, B. A., and Crowley, W.: A.M.A. Arch. Int. M. 95:653, 1955. 2. Perry, R. E., Jr.: North Carolina M. J. 16:567, 1955.

NITROFURANS—A NEW CLASS OF ANTIMICROBIALS—NEITHER ANTIBIOTICS NOR SULFAS

Eaton LABORATORIES

providing comfort for the patient. I received a backrub once a day with my bath, but it would have been much more appreciated in the evening.

I know how I felt when I received inadequate nursing care. To the average lay person, such care is a sad reflection on nurses.

On my return to nursing, I shall certainly perform all the tasks taught me in my training days—to make each patient's stay in the hospital as comfortable and as pleasant as possible.

(Mrs.) CHARLENE WALTON, R.N.
ALEXANDRIA, VA.

CANCER CLUB

Dear Editor:

We have received a great deal of interesting mail since you published Francelia Butler's article, "A Message of Hope," in your Nov. 1955 issue. One letter was from a nurse who is eager to organize a cancer club in New York City. Your readers have taken a genuine interest in the work we are doing.

(MRS.) PRISCILLA DEXTER KERN
PRESIDENT
CURED CANCER CLUB
WASHINGTON, D.C.

INVENTIONS

Dear Editor:

The head of our research and development program is very enthusiastic about your February article, "The Patents of Pauline." He finds it to be one of the finest he has ever seen on the subject of inventions and patents, and would

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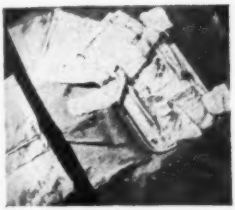

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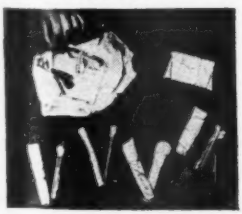

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EDWIN B. ROBERTS
AMERICAN HOSPITAL SUPPLY CORPORATION
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LEGAL ISSUES

Dear Editor:

There is so little written concerning the legal aspects of nursing that a great many nurses don't know exactly where their responsibility begins and ends. For instance: If a director of nursing wants aides to give hypos, treatments, and medications, does the head nurse have to comply? Who becomes responsible in such a case—the head nurse, the director, or the hospital?

Would it be possible to provide a synopsis of the legal aspects of nursing?

Thanks so much for your wonderful magazine. It keeps up my nursing knowledge and gives me moral support.

(Mrs.) RITA W. FREDERICK, R.N.
BLOSSBURG, PA.

[Nursing Practice and The Law *by Milton J. Lesnik and Bernice E. Anderson (Lippincott), offers a full explanation of the nurse's legal responsibilities. Obviously, no synopsis of its 400 pages is possible here. The most important fact to remember, says co-author Anderson, is that "each person is*

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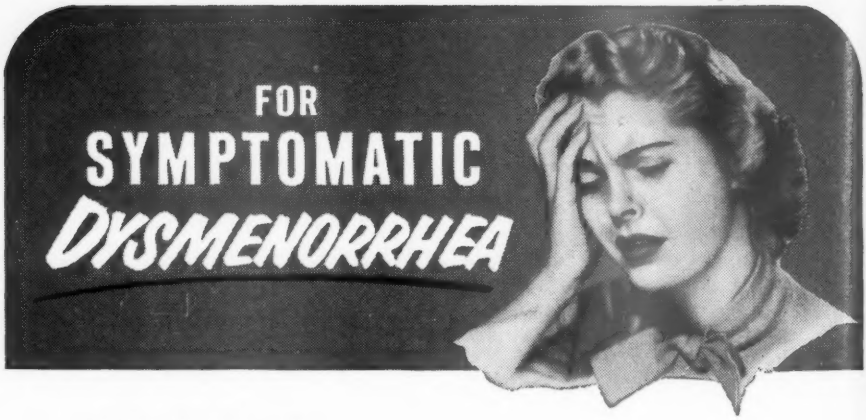
responsible for his own negligent actions . . . although employers may also *be responsible. The fact that an order is given by a responsible person (such as the director of nurses or a doctor) does not excuse the head nurse or the floor nurse if negligence ensues. No person should carry out an unreasonable order.*

"Supervising nurses have been held liable in court for the negligence of incompetent subordinates whose delegated duties they didn't supervise personally. The responsibility of a director of nurses, head nurse, or any other supervisory nurse is to determine (a) what can safely be entrusted to others, and (b) the degree of competency of the individual to whom a specified duty is delegated.

"Medical acts (such as the giving of hypos, medicines, and treatments) can only be performed under the order, direction, and supervision of a licensed physician. The nurse's right to perform such an act is conditional upon her capacity to understand and execute the order. In a malpractice case, she is entitled to no consideration merely because she alleges that she was ordered to perform a certain function. An aide would be in no position to have adequate understanding of cause and effect in the execution of medical acts. She would, however, like the nurse, be responsible if a patient were injured due to her negligence."—THE EDITORS]



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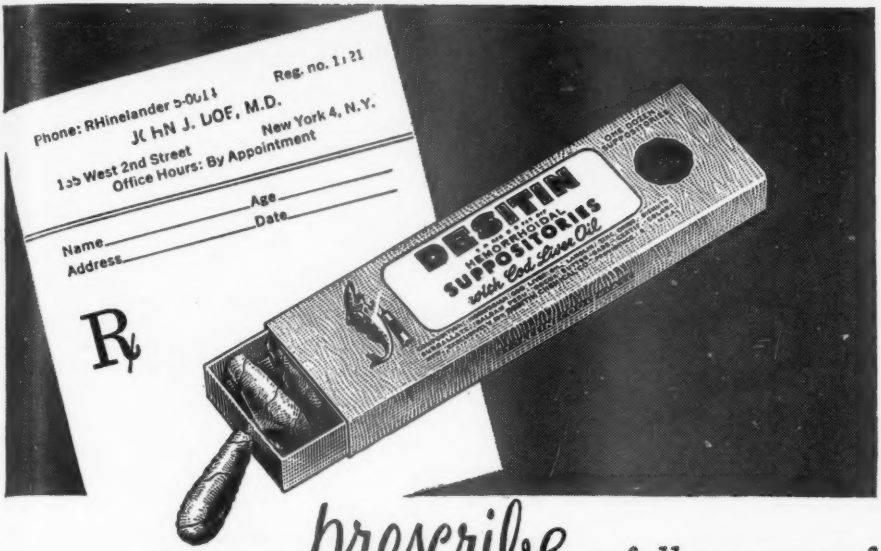

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(9 out of 10 cases cleared up or definitely improved)

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CLEARASIL is the new-type scientific medication developed *especially* for the treatment of pimples. Doctors and skin specialists have proved its effectiveness in controlled clinical tests. In these tests on 202 patients, 9 out of every 10 cases were cleared up or definitely improved while using CLEARASIL.*

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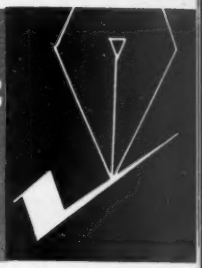
as the other two largest-selling filter brands!

Viceroy's Exclusive Filter Is Made From Pure Cellulose—Soft, Snow-White, Natural!

LITERATURE & SAMPLES



SILK SUTURES: The manufacture of silk surgical sutures under controlled conditions is the subject of a booklet offered by DAVIS & GECK, INC. Photographs of manufacturing processes are used liberally and instructively. **E 1**

UNIFORM FASHIONS: This Spring-Summer catalog is filled with descriptions of the newest professional garments manufactured by WHITE SWAN UNIFORMS, INC. **E 2**

SKIN HEALTH: Hollandex Silicone Ointment contains natural cod liver oil, with vitamins A and D, and a mild and non-irritating antiseptic in a lanolin base. Hollandex is described as a medicated ointment for tender skin rather than a cosmetic. A sample is offered. HOLLAND-RANTOS CO., INC. **E 3**

POPLIN FOR UNIFORMS: New Kendall Nurses' Poplin never needs starching and resists soil and wrinkles. According to the manufacturer, it bleaches white, dries quickly, and irons in a jiffy. Samples of fabric and literature are offered. KENDALL MILLS. **E 4**

SPHYGMOMANOMETERS: Nurses entrusted with blood pressure determinations, particularly private duty nurses, may wish to see this folder, which illustrates and describes the sphygmomanometers of PROPPER MANUFACTURING CO., INC. **E 5**

THE COST OF MEDICAL CARE: Two folders, "Concerning one of the biggest bargains of your life," and "How much does it cost to keep him well today?" are offered by PARKE, DAVIS & CO. **E 6**

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R.N.—A JOURNAL FOR NURSES
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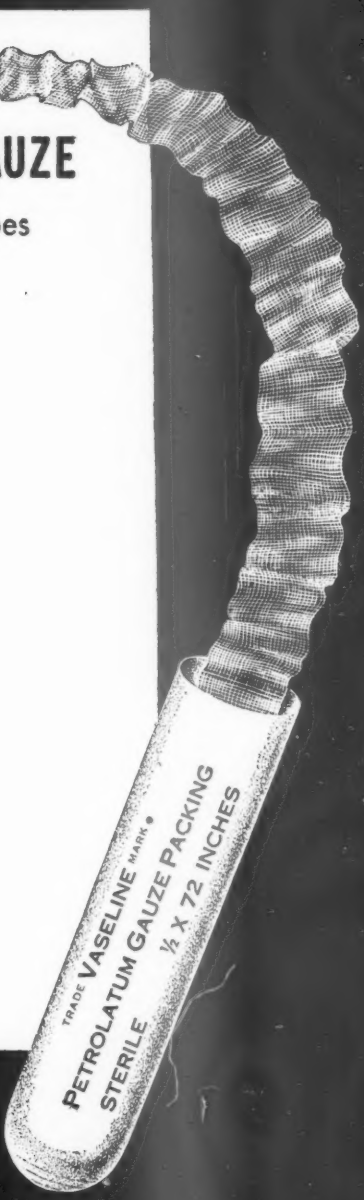

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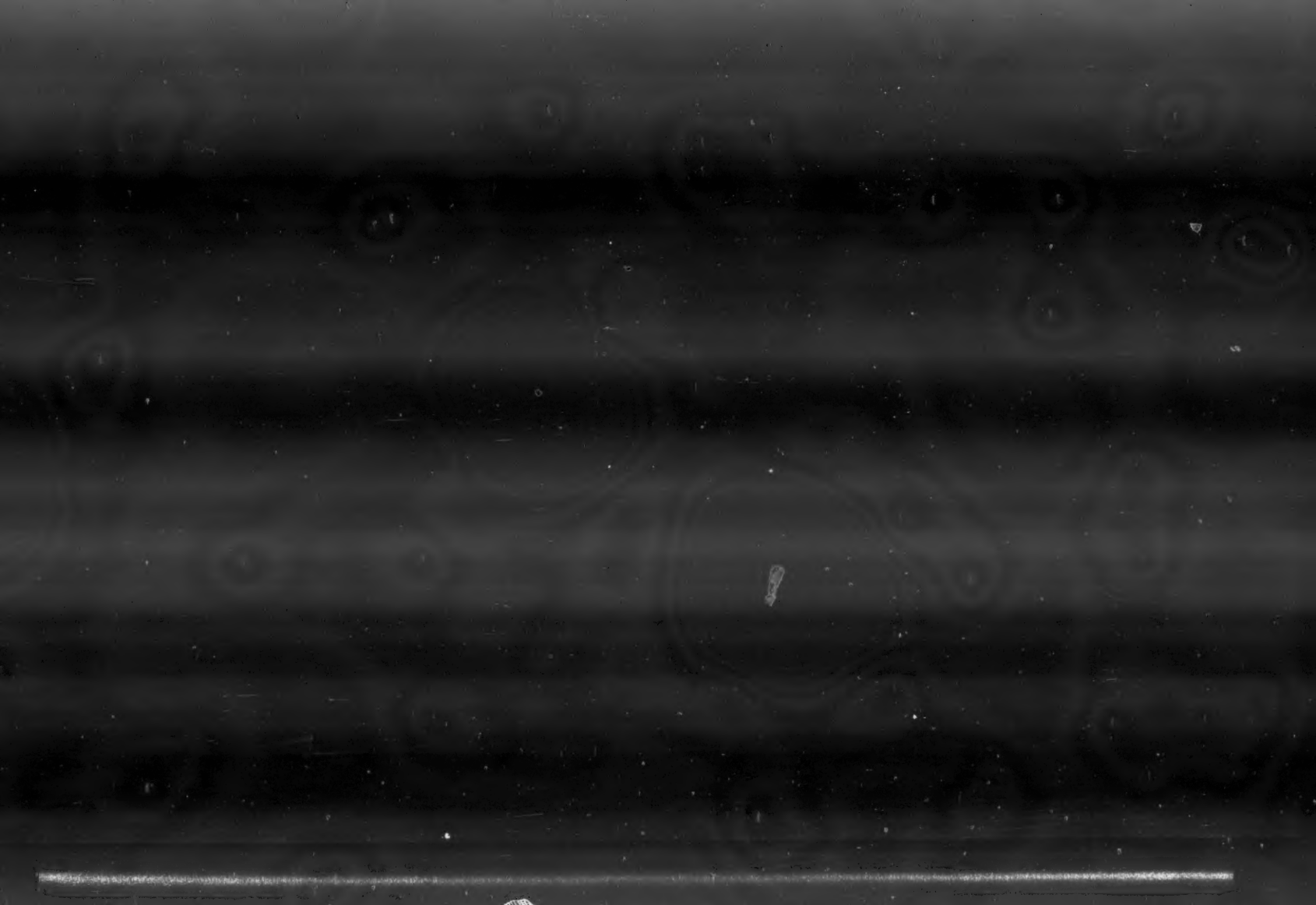

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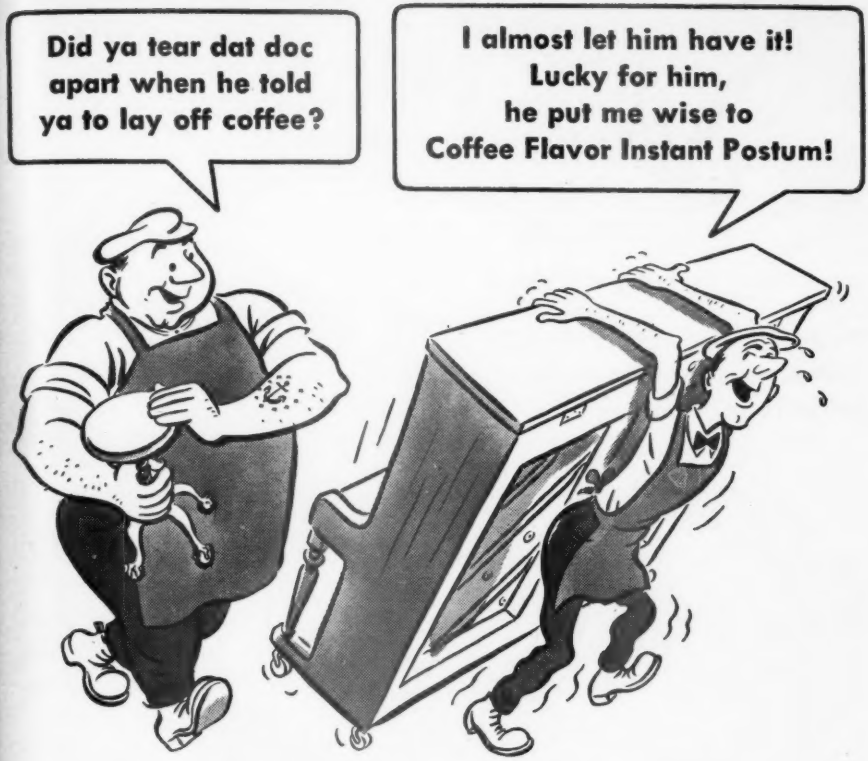

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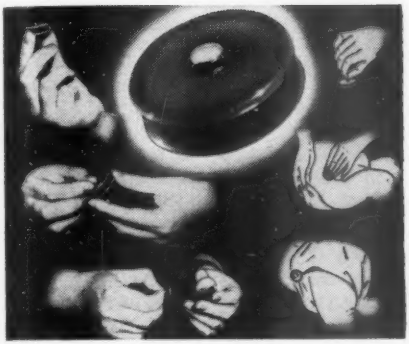

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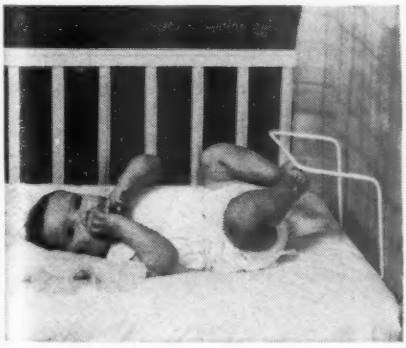

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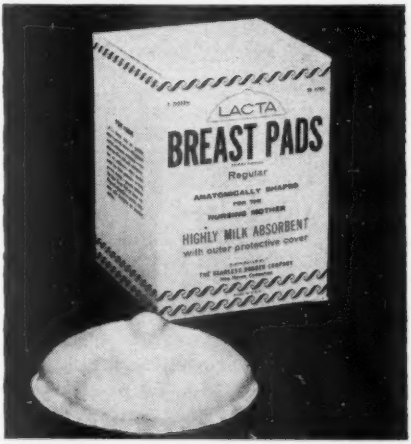

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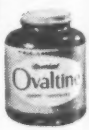

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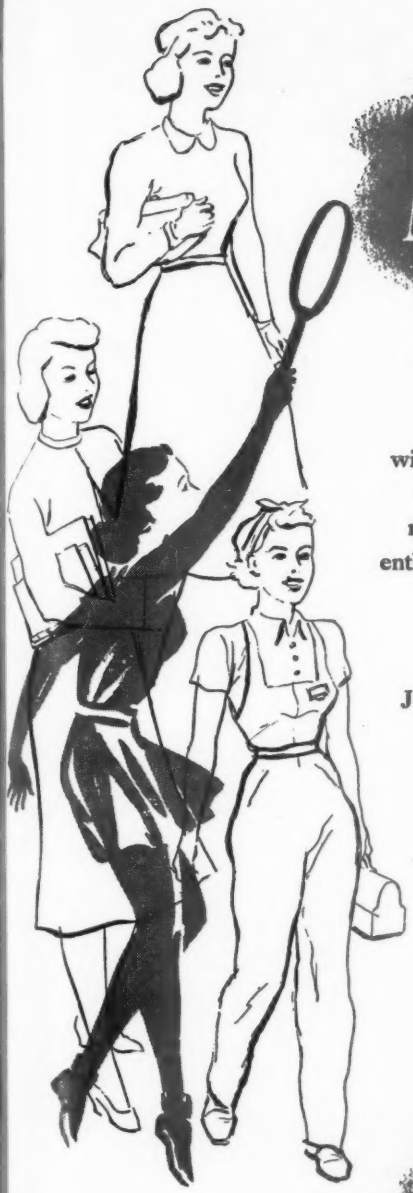

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DISASTER

"Hiroshima Diary"

PEARL HARBOR, Hiroshima, and Nagasaki should have taught us the importance of disaster-planning. Instead, "the bomb" of August 6, 1945 gave rise to a strange philosophy: a resignation to total destruction took hold of our people, and apathy toward Civil Defense programs resulted—with only the dismal overtones of the spokesmen of Despair being heard. But now the picture is changing. The floods, tornadoes, and other catastrophes of the past two years are evidence that Nature on a rampage can drive home the lesson of preparedness more forcibly than an A-bomb threat. As each new destructive blow of Nature hits a region, the same story is repeated: the stricken community turns instinctively to one focal point for relief—the local hospital. Thus have our hospitals had disaster-planning thrust upon them. Many which have previously ignored it are now readying their staffs to cope with mass casualties; and since nurses should know what's developing, *R.N.* is devoting a major part of this issue to the subject, with special emphasis on the new role which the nurse will have to assume as the doctor's first assistant.—THE EDITORS

EXCERPTS *from a graphic account of how one hospital actually fared under the impact of nuclear warfare by a Hiroshima hospital director and doctor, who chronicled the post-bombing period in the recently published* Hiroshima Diary.*

The Bomb—August 6, 1945

CLAD in drawers and undershirt, I was sprawled on the living room floor exhausted because I had just spent a sleepless night on duty in my hospital.

Suddenly . . . a strong flash of light startled me . . . then another. Garden shadows disappeared . . . Through swirling dust I could barely discern a wooden column that had supported one corner of my house. It was leaning crazily and the roof sagged dangerously.

Moving instinctively, I tried to escape, but rubble and fallen timbers barred the way. A profound weakness overcame me. I stopped to regain my strength. . . . I discovered that I was completely naked.

What had happened?

All over the right side of my body I was cut and bleeding . . .

*Excerpted from *Hiroshima Diary* by Michihiko Hachiya, M.D. Translated and edited by Warner Wells, M.D. (The University of North Carolina Press, Chapel Hill, N.C.) Price: $3.50.

A large splinter was protruding from a mangled wound in my thigh . . . something warm trickled into my mouth . . . My cheek was torn; the lower lip laid wide open. Embedded in my neck was a sizable fragment of glass, which I dislodged with the detachment of one stunned and shocked . . . I studied it and my blood-stained hand.

[My wife and I] stood in the street, uncertain and afraid . . . a house across from us began to sway and then with a rending motion fell almost at our feet. Our own house began to sway, and in a minute it, too, collapsed in a cloud of dust. Fires sprang up and whipped by a vicious wind began to spread.

It finally dawned on us that we could not stay there in the street, so we turned our steps towards the hospital . . . Our home was gone . . . we were wounded and needed treatment . . . it was my duty to be with my staff.

The Hospital—

Patients had become packed, like the rice . . . into every nook and cranny of the hospital. The majority were badly burned, a few severely injured. All were critically ill. They came as an avalanche and overran the hospital.

There was no friend or relative to minister to their needs, no one to prepare their food. Everything was in disorder. There was the vomiting and diarrhea. The front entrance became covered with feces overnight, and nothing could be done for there were no bed pans and, even if there had been, no one to carry them to the patients.

Disposing of the dead was a minor problem, but to clean the rooms and corridors of urine, feces, and vomitus was impossible . . .

The people who were burned suffered most because as their skin peeled away, glistening raw wounds were exposed to the heat and filth.

Sorting—

An effort was made to sort and rearrange the patients according to the nature and severity of their injuries, and not a few dead were found among the living. It irritated me when I heard the report for I felt that the dead should be moved with greater dispatch in order to make room for the living. This is another example of my changed outlook. People were dying so fast that I had begun to accept death as a matter of course and ceased to respect its awfulness. I considered a family lucky if it had not lost more than two of its members.

The Casualties—

Here was an old lady, on the verge of death, in nothing but an undershirt . . . a horribly burned young man, lying completely naked on a pallet. There was a dying young mother with breasts exposed, whose baby lay asleep in the crook of her arm with one of her nipples held loosely in its

[*Continued on page* 69]

planning for DISASTER

THE SURGEON SPEAKS*

PLANNING is all very well for a flood or a small disaster, but how do you prepare for a bombing attack that leaves millions of casualties in its wake? How do you cope with a catastrophe which would produce about 500 casualties per doctor?

First, don't be dismayed into a do-nothing attitude by the enormity of it all. Our Civil War doctors cared for more casualties during the three-day Battle of Gettysburg than were injured at Hiroshima. Besides, most of us have had some experience with military casualties, and these are no different from civilian ones. It's just that we haven't given enough thought to the management of disaster victims.

The fact is you can't expect plans to take care of every aspect of an emergency; but if you have a plan in which everyone knows his disaster role, you're that much farther from chaos and confusion, no matter how great the disaster.

It's true, however, that in preparing for a catastrophe like an atomic blast, we've got to adopt a new philosophy of treatment—one that may go against our professional grain. We're not used to classifying people as "hopelessly injured," or deferring the care of the seriously wounded. This mass-casualty philosophy, known in the

*Adapted from talks presented at meetings of the American College of Surgeons, Feb. 13-16, 1956, by Col. Joseph D. Goldstein, MC, Cletus W. Schwegman, M.D., Col. Joseph R. Shaeffer, MC, and William T. Fitts, Jr., M.D.

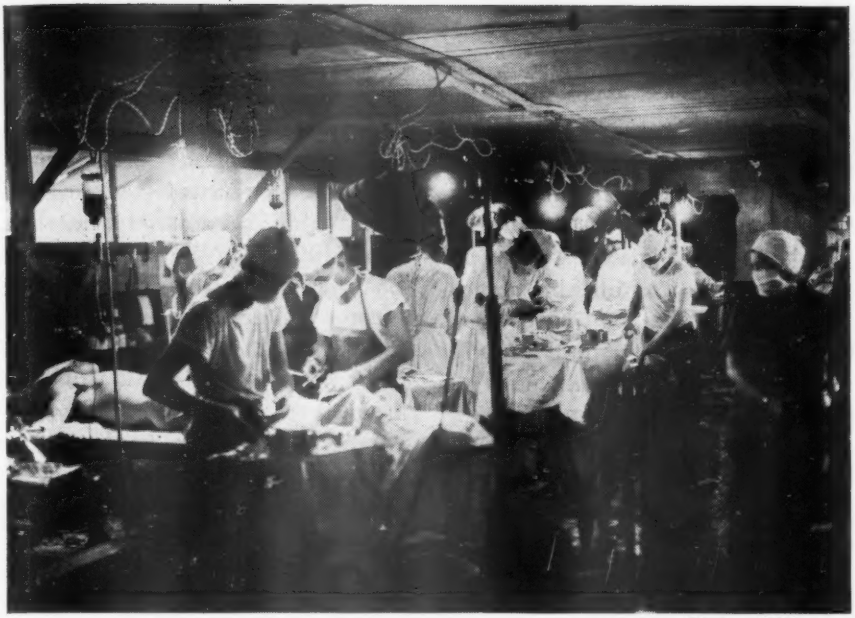


Photo: U.S. Army

military as *triage*, isn't being taught in medical schools, nor is it being followed in our hospitals today. Nevertheless, we'd better incorporate it in our plans if we're going to make any real headway in an all-out bombing.

Disaster experts agree that it's possible to care for tremendous numbers of casualties if we're willing to follow one principle: that of providing the best care for the most with the little we will have to do it with. This means that we've got to revise our thinking. It means that in the event of an all-out bombing attack:

▶ Every doctor—general practitioner or specialist—will become a surgeon.

▶ Experienced surgeons will be in charge of sorting the injured for priority treatment. These *triage* teams will decide what type of treatment each patient requires—and whether immediate treatment is advisable.

▶ Procedures usually done by doctors will be done by veterinarians, dentists, nurses, and others with training in professions allied to medicine. All of the doctors will act as supervisors, directors, and teachers.

▶ Patients who now receive minimal professional care will receive none during the emergency period (which may last for 72 hours). Everyone in this group will be his or her own doctor for the time being.

▶ The first to come to a hospi-

tal, the walking wounded, will be treated if necessary and returned to their jobs. A second group will require surgery and lifesaving measures. Those in the third class can wait 72 to 96 hours without too much of an additional risk. The last group will include the hopelessly injured who will be put aside, made as comfortable as possible, and attended to as soon as the work load permits. Supplies and time will not be expended on this group.

▶ Complicated surgery will not be performed during the emergency period, because a surgeon could be taking care of some 200 minor casualties in the time needed for one major operation.

▶ Unnecessary treatments (especially those that will prolong disability) will not be given.

▶ About 70 per cent of patients already in the hospital will be released so that beds will be available for casualties.

The rules that we and our assistants are going to follow in caring for survivors are simple and surgically effective. Emergency treatment will consist mainly of first aid for burns, trauma, and shock. Persons exposed to enough radiation to cause more than the mildest illness may have nausea and vomiting, but unfortunately there is no emergency treatment for radiation casualties other than supportive care.

Patients with burns covering up to 15 per cent of the body's surface will probably have to resort to self-treatment (ointments, dressings, oral fluids). Many in this group should be able to continue to be active once their pain is alleviated. Those with 15 to 30 per cent of their body area burned will probably have to take most of their fluids by mouth for a while, depending upon the availability of I.V. fluids. A solution consisting of one gallon of water, two tablespoons of soda bicarbonate, and three tablespoons of salt will serve as oral therapy (the 1-2-3 formula). How much can be done when burns cover more than one-third of the body is contingent upon such factors as the availability of antibiotics and I.V. solutions—as well as upon the patient's age, condition, exposure to radiation, etc.

Rarely, if ever, will wounds be sutured under disaster conditions. During the Worcester disaster, all but 25 of 1,500 tissue wounds were closed, and 95 per cent broke down after six to eight weeks. Soft tissue wounds will need debridement, and oozing hemorrhages must be controlled by dressings that will guard against infections. Each of us must know how to put on a dressing—not fancy dressings but practical ones fashioned from the cleanest material available (shirt sleeves or anything else).

A good rule to follow in caring for fractures is to splint patients where they lie. We're not going to have a lot of ready-made splints around, so we'll have to get used to improvising with well-padded pieces of wood, rolled-up maga-

zines, etc. Fractured extremities should be made as immobile as possible. If splinting material is not available, legs can be tied together and the arms immobilized with a body bandage. Skull and spinal fractures will be handled according to accepted first aid principles.

There won't be time for surgical consultations. Immediate decisions will have to be made—if we're going to do the best for the most. When blood vessels, nerves, bones are shattered, limbs are going to have to be amputated. With amputation completed, the patient can be ambulatory much sooner. Many patients will have injuries about the jaw, face, and neck, necessitating tracheotomies: *surgeons, not nurses, must do these, for they're not simple procedures.*

The three things that kill people in catastrophes are hemorrhage, shock, and obstruction of breathing. Most bleeding can be controlled by the thumb, and it need not be the surgeon's thumb if the pressure points are known. A pressure bandage is preferable to a tourniquet, which may doom a limb to amputation if not removed after a certain period of time. Moreover, to loosen a tourniquet after massive hemorrhage may be fatal.

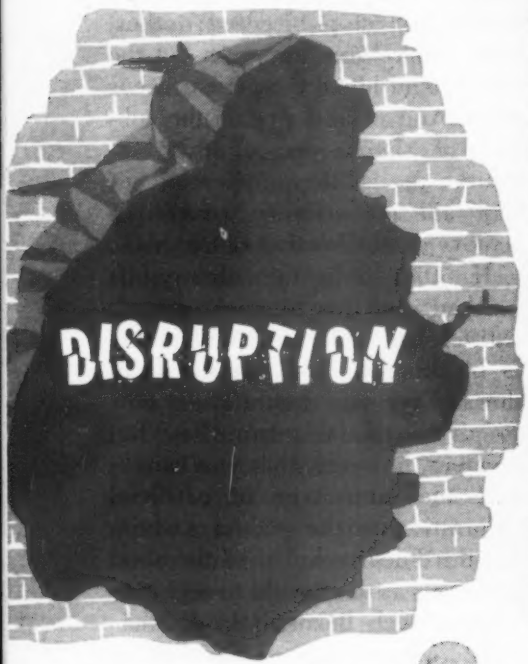
In shock, type O blood will be used if available, but I.V. saline works well and exerts its effectiveness for at least two hours. Plasma expanders, Dextran, and other materials, including I.V. Gelatine, are also helpful. However, there's no point in using plasma expanders unless you stop bleeding; otherwise, you're going to wash out the elements of blood the patient needs most. And while we're on the subject of shock—one of the best treatments is the application of first aid measures to relieve or remove conditions that cause shock.

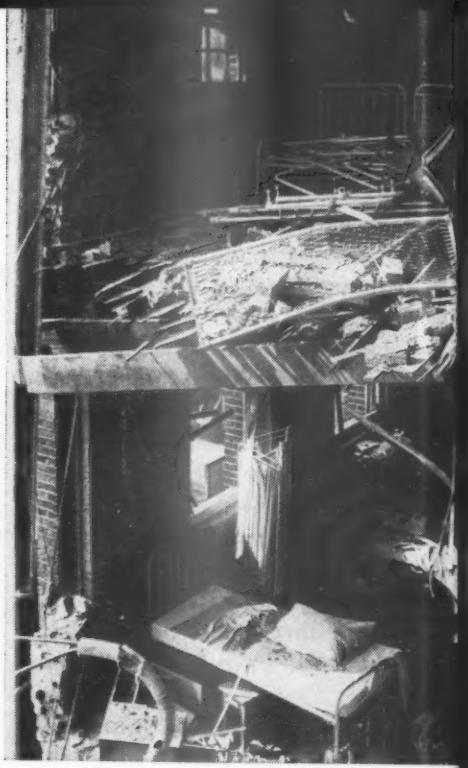
If the patient's airway is blocked, pull his tongue forward, extract from his mouth whatever is blocking it, and put his head down. Everyone should know how to give artificial respiration. Remember, however, that you cannot give the same type of artificial respiration to the person sustaining third-degree burns of the chest and arms as you would to a person without such burns.

There are many differences of opinion about priority of casualty treatment. In general, priority will be given to those who can be saved. Intercranial injuries may not receive top priority. Brain injuries usually live; those that don't, die promptly, even with treatment. Chest injuries are not a threat to life; large, sucking wounds of the chest can be converted into satisfactory wounds by the simple application of big dressings. The intra-abdominal injuries may be fatal after a relatively short delay, but you can't do a lot of abdominal surgery under disaster conditions. You try to close the abdominal wound with anything you've got and hope that peri-

[*Continued on page 71*]

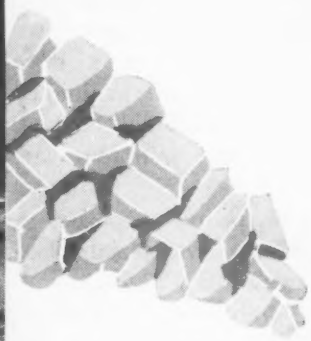
. . . none are immune





. . . none so desolate

. . . none so weary



. . . none so homeless

yet none so indestructible!

WE MUST all remember that disaster victims are not only affected physically by burns, trauma, and shock; they are also prone to emotional disturbances and hysterical reactions. Therefore, we will have to know how to give psychological first aid as well as surgical help.

It's important for both medical and non-medical personnel to understand the principles of psychological first aid because all disaster workers will be assisting people who are under great stress. Psychiatrists will not be able to help in wide-scale disasters; they'll be taking care of the physically wounded.

Contrary to past belief, the types of illnesses that fill our mental hospitals—the schizophrenias, prolonged depressions, etc.—do not occur under disaster conditions, bearing out the assumption that mental disorders are caused by internal conflicts rather than by external dangers. Psychiatric disaster casualties are more likely to have temporary rather than prolonged disruptions of emotional control, which may last for a minute or several days.

Studies of people exposed to combat and massive aerial bombardment in World War II, including atom bomb victims of Hiroshima and Nagasaki, as well as persons in civil disasters, show that there are five general types of reactions to disaster: (1) normal behavior; (2) individual panic; (3) depressed reactions; (4) over-activity; and (5) bodily reactions.

The Uprooted
as seen by British artist Henry Moore

From our own experience, we can probably recall persons who were calm and poised in the midst of a harrowing event. Such stoical individuals, though, are in the minority. Most of us tend to lose our composure and show signs of disturbance such as sweating, trembling, and, literally, knocking of the knees. These reactions are not unusual and are generally transient.

In a disaster, we should assume that most persons will gain some control of their emotions in a reasonable period of time. Psychological first aid is needed only by those who are obviously losing their self-control or who do not seem to be regaining some degree of effective behavior.

Fortunately, panic is not common, but when it does occur, there are disastrous consequences. A

Psychological First Aid*

small group, fleeing from imminent danger—real or presumed—can easily precipitate a mass panic that will lead to irrational attempts to escape. Thus, we have unnecessary deaths in theater or night club fires when crowds rush for one exit even though more are available. Other forms of individual panic are purposeless, helpless behavior, such as uncontrollable shaking and weeping.

Mass panic is generally caused by blocked escape routes. In Hiroshima and Nagasaki, for example, panic was created by the fire storm following the atomic explosion. In headlong flight from the burning buildings to the river, persons were caught between the strong currents of the river and the flaming river banks. According to *Hiroshima Diary*, "Hundreds upon hundreds jumped or were pushed in the river . . . and most were drowned."

Another mass panic with tragic consequences occurred in London during World War II when a woman carrying a baby stumbled and fell on steps leading to an air raid shelter. Those behind her also fell, piling up, one on top of the other, and crushing the life out of those in front of them. In all, 178 persons were killed and about 60 injured . . . and no bombs fell.

Early segregation and control of "panicky" persons is advised so they will not disturb others or start a general panic. If gentle firmness fails, enlist help and escort them to a medical aid station. If there is no medical help at hand, ask two or three volunteers to take over until help arrives. Although physical restraint may be used, it should not be brutal or punitive. Never slap hysterical persons, nor douse them with cold water, nor abuse them in other ways.

Depressed victims, who act as though they were struck dumb by the event, seem to have no emotional reactions at all. Yet these persons respond best to sympathetic attention. A short time spent in conversing with them, individually or collectively, will pay dividends in rousing them to constructive ac-

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*Condensed from a manual on psychological first aid published by the American Psychiatric Association, 1785 Massachusetts Ave., N.W., Washington 6, D.C., with additional material from a talk by Col. Albert J. Glass, MC, at a meeting of the American College of Surgeons, Feb. 16, 1956.

tion and getting them to perform simple, routine tasks. Even though a casualty may not respond to your overtures at first, he is forming an opinion of you, and this opinion will be shown in his later reactions.

Those with overly active responses, who indulge in pointless talking, joking, and offering numerous suggestions, seem to have undue confidence in their abilities. As a result, they're apt to be intolerant and critical of the opinions of others.

Under proper supervision, overly active individuals will slowly regain some composure, though it may be difficult to communicate with them at first. Since they have a great need for physical activity, they can be assigned to such work as rescuing casualties or clearing rubble. Above all, don't try to argue the rightness or wrongness of their views on the disaster situation. Show them that it is much more urgent to repair the damage as soon as possible. Work will help to dissipate destructive attitudes which, if allowed to spread, can lead to a serious crisis.

Often we may observe severe bodily reactions in disaster victims. It should be noted that severe nausea and vomiting may result from an emotional disturbance as well as from serious exposure to radiation or biological and chemical warfare agents. Another disabling reaction is "conversion hysteria," in which an individual unconsciously converts anxiety into a belief that [*Continued on page* 72]

THE greater the disaster, the greater the need for medical and nursing preparedness. In an atomic catastrophe, nurses must be prepared to extend their functions immediately in two directions: in patient treatment and in nursing supervision.

Recently a medical authority on Civil Defense gave us some idea of the extent of these functions by questioning our training in the following areas: (1) management

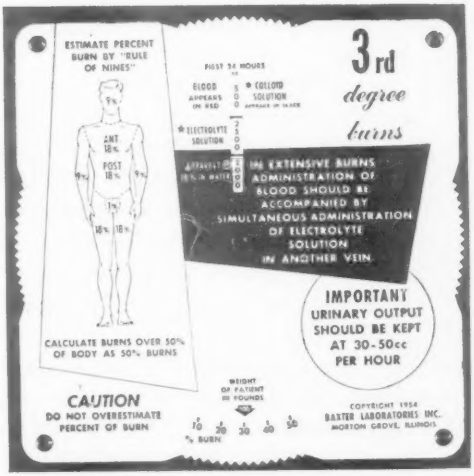
*Adapted from a speech given by Maj. Harriet H. Werley, ANC, at a meeting of the American College of Surgeons, Feb. 16, 1956.

THE NURSE SPEAKS*

and supervision of wards without a physician; (2) the essentials of handling wounds, including debridement, suturing, etc.; (3) the administration of antibiotics, narcotics, and sedatives, without reliance on the physician, and (4) treatment of mild clinical cases.

There's no denying that practical and realistic thinking is needed. If we're going to help doctors give the best care to the greatest number, we will be expected to treat and prevent shock, maintain electrolyte and fluid balance, relieve pain, cleanse wounds, and apply dressings. In most of these procedures we shall have to rely on simplified methods.

For instance, in caring for extensive body burns, we can use the "Rule of Nines" in conjunction with the recently developed fluid calculator to determine percentage



For rapid reference in treating large numbers of burn casualties, Baxter Laboratories' pocket-sized celluloid calculator helps to estimate early fluid requirements. Based on a formula developed at Brooke Army Medical Center, and distributed by American Hospital Supply Corp., Evanston, Ill., the reversible calculator computes requirements for both second and third degree burns. When patient's weight in pounds and per cent of body surface burned are "dialed" on lower scale, requirements of blood, colloid solution, electrolyte solution, and dextrose in water appear on top scale. The "Rule of Nines" for estimating percentage of body surface burned is shown at left.

of body surface burned and estimate fluid requirement. The "Rule of Nines" assesses the body area in multiples of 9 per cent: trunk 36 per cent, head (adult) 9 per cent, each leg 18 per cent, each arm 9 per cent, and perineum 1 per cent —total 100 per cent.

Simplified guides of this sort cannot supplant the minimal judgment of physicians, but they are helpful in emergency situations.

Both the intravenous and anesthesia work-load will be carried by nurses in the event of a large disaster. The fully qualified nurse anesthetist will be capable of supervising several anesthetic procedures carried on simultaneously. Other nurses will give anesthesia after completing short, condensed courses or on-the-job training. The delivery of uncomplicated maternity patients will also be handled by nurses while obstetricians are performing essential surgery.

In a wide-scale disaster, nurses will be upgraded to assist with medical care whether it's given in a first aid station or hospital. Although nurses can best function within their own specialties, they will need to be adaptable. When catastrophe strikes, there will be no time to reshuffle and reassign staff members. During the post-impact period all R.N.'s will have to serve as competent surgical assistants.

If we, as nurses, are to meet our administrative and supervisory responsibilities, we must also improve our skills and techniques of supervision. Only then can we properly direct and guide others in giving emergency care. Good supervision is essential to utilize large numbers of partially trained or untrained personnel.

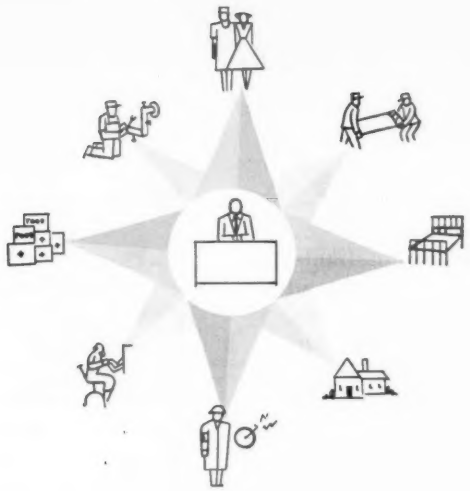
How can we prepare nurses for their expanding role in disaster? The fundamentals of disaster nursing should be integrated in the curriculum of all our nursing schools; but since we cannot wait for the schools to turn out their finished products, the urgency for preparation rests with nursing service agencies and their directors.

These agencies can capitalize on the ever-present teaching-learning opportunities in daily practice. For example, their nurses can study the care of burns: learn how to judge the patient's condition by observation alone—the quality of the pulse, the feel of the skin; or practice splint-making with makeshift materials.

To assure proper functioning of a staff in a surgical set-up, an orderly plan of rotation should be worked out providing experience on surgical wards, in the operating room, and in the emergency clinic. If properly planned, rotation should not cause too much disruption. In fact, it should not be thought of as disruption but rather as a means of stockpiling surgical knowledge.

Various subjects might be included in an in-service training program: the control of hemorrhage, the application of dressings,

[*Continued on page* 74]



Administrator's DISASTER Check List

THREE inescapable facts emerge from actual hospital experience in coping with the severe floods, fires, atomic explosions, and other headlined disasters of recent times:

¶ Civil Defense, police, and the public turn instinctively to hospitals for almost every imaginable kind of emergency help—and not to the largest but the *nearest*.

¶ No hospital, however small, can disregard the need for a stand-by plan, prepared in advance, for handling a sudden influx of casualties; and while no plan can be perfect (since no two disasters are exactly alike), even a far-from-perfect one is better than none.

¶ To the administrator—key figure in any hospital set-up—belongs the responsibility of devising the plan; getting it down on paper; keeping it up to date; coordinating it with the plans of neighboring hospitals, Civil Defense, Red Cross, and armed forces; and conducting the necessary periodic drills without which its worth cannot be tested.

Some authorities suggest that the planning be directed by a committee, with the administrator as chairman; but whether the latter acts individually or with others, the plan itself will bear scrutiny, both in preparation and review, to be sure that no essential point is overlooked. With this in mind, R.N. has prepared the following check list for the guidance of the administrator. It is based entirely upon the warnings and recommendations of those who have suddenly had to deal with mass casualties —plus power failure, water contamination, jammed switchboards, and other disaster-created conditions.

MAINTENANCE

- ☐ Emergency current for lights, elevators, refrigeration, oil burners, kitchens, laundry, therapy, x-ray, sterilizers, etc.
- ☐ Emergency sources of water for drinking, bathing, sanitation, kitchens. (Artesian wells; use of dairy tank trucks, milk cans; installation of storage tanks or reservoir.)
- ☐ Instruct employes to fill bathtubs, whirlpools, and Hubbard tanks with tap water at first alert.
- ☐ Measures for conserving water. (Use of commercial laundries; limit patient-bathing to sponge baths.)
- ☐ Sanitation measures. (Bucket flushing of toilets; covered receptacles for emptying bedpans; carting away and dumping of refuse.)
- ☐ Install unlisted phones at strategic points to provide outgoing lines when switchboard is jammed with incoming calls.
- ☐ Shortwave radio communication (in case phone service is cut off).
- ☐ Adequate intercom facilities to supplement internal phone system.
- ☐ Fuel reserves for boilers, generators, oil burners, and water heaters.
- ☐ Install emergency outlets for iron lungs, oxygen tents, and incubators.

PERSONNEL

- ☐ Phone and radio round-up of off-duty nurses, doctors, others.
- ☐ Procure official passes (and windshield stickers) for all personnel—in case police lines must be crossed to reach hospital or disaster scene. (Issue passes *now*.)
- ☐ Train all employes (especially new ones) in their disaster assignments.
- ☐ Base individual assignments on regular duties. (People can't be expected to handle unfamiliar work in time of crisis.)
- ☐ Recruit emergency nurses, aides, orderlies, phone operators, etc.
- ☐ Arrange to obtain M.D.-R.N. teams from other hospitals.
- ☐ Instruct personnel to report to other hospitals if unable to reach their own.
- ☐ Organize volunteers to act as messengers and chauffeurs, carry trays, police entrances, help in kitchen and laundry, staff information desk, chaperone children, aid maintenance men, handle supplies, relieve elevator and phone operators.
- ☐ Plan secondary system for alerting off-duty personnel through "chain" phoning. (Example: Key employe phones four others, each of whom alerts four more; principle then repeated till all are alerted.)

planning for DISASTER

SUPPLIES

- ☐ Check reserves: drugs, blood, oxygen, I.V. solutions, dressings, appliances, syringes, needles, linen, mattresses, cots.
- ☐ Establish emergency sources for all major items. (Consider: other hospitals, pharmaceutical houses, radio appeals for specific needs.)
- ☐ Distribute disaster boxes containing supplies, instruments, etc., at needed locations in hospital.
- ☐ Ready first aid boxes for use at disaster scene. (Instruct teams sent to first aid stations and evacuation centers to take their own supplies.)
- ☐ Plan to set up and man emergency bleeding center at or near hospital. (List available stand-by donors.)
- ☐ Check sources of dry ice for preservation of food, blood, bones, biologicals.
- ☐ Provide extra storage facilities for emergency supplies.
- ☐ Insure that records be kept of rushed-in supplies, whether ordered or donated. (Donations should be acknowledged later, and unused supplies should be returned.)

CASUALTIES

- ☐ Allocate extra space adjacent to regular accident entrance for (a) sorting casualties, (b) giving first aid.
- ☐ Provide sorting area with cots, tables, wooden horses to hold stretchers. (Casualties should be kept off floor.)
- ☐ Provide tags for sorting.
- ☐ Provide first aid area with disaster boxes. (Check contents for: drugs, medications, blood, instruments, dressings.)
- ☐ Check first aid needs for: burns, fractures, severed tendons, lacerations, puncture wounds, contusions, immersion, exposure, shock, hysteria, women in labor.
- ☐ Provision of ambulance service and first aid at disaster scene. (Don't deplete hospital staff in dispatching aid.)
- ☐ Provide for rapid transfer of casualties from sorting area to first aid area and/or in-patient facilities. (Consider use of cots and fold-away beds for casualties admitted for in-patient care.)
- ☐ Identification of dead, safekeeping of their valuables, removal to morgue.
- ☐ Provision for casualty record-keeping on as-complete-as-possible basis. (Hospital may be reimbursed later by Red Cross for first aid services rendered.)

IN-PATIENTS

- ☐ Provide for prompt transfer or discharge of ambulatory patients (especially those in for diagnosis only) to make beds available for the disaster victims.
- ☐ Insure that seriously ill cases won't be neglected if many M.D.'s and R.N.'s are needed elsewhere.
- ☐ Restrict non-emergency admissions for time being.

COMMUNITY ASSISTANCE

- ☐ Provision for anti-typhoid inoculations of general public.
- ☐ Measures to handle possible aftermath epidemic of febrile and enteric diseases.
- ☐ Lab tests to insure safety of drinking water.
- ☐ Emergency supplies for distribution to local first aid stations and evacuation centers. (Check: aspirin, antibiotics, gauze, disinfectants, diapers, linen, baby formulas.)
- ☐ Availability of helicopters for distribution of supplies, rescue work, etc. (Provision of landing space at hospital.)

FOOD

- ☐ Check reserves of canned goods.
- ☐ Establish emergency sources for major items—milk, bread, eggs, fruit juices, etc.
- ☐ Check possibility of having food prepared by hotel or restaurant kitchens.
- ☐ List other hospitals that can supply baby formulas.
- ☐ Consider emergency substitution of cold-food menus (including canned meats, salads, fruits, etc.) for feeding in-patients and staff members.
- ☐ Use of paper plates to eliminate dishwashing.
- ☐ Plan to set up emergency feeding stations to dispense coffee and sandwiches to volunteer workers, police, delivery men, etc.
- ☐ Arrange to have house-to-house delivery men dump surplus perishables (milk, bread, etc.) at hospital.
- ☐ Consider possibility that hospital may have to send food to staff members at disaster scene, inoculation centers, etc.
- ☐ Broadcast an appeal for oil stoves if kitchen equipment can't be used.

planning for DISASTER

INQUIRIES

- ☐ Establish central information center (near main entrance, switchboard).
- ☐ Chaplains to assist in answering inquiries about casualties, comforting relatives.
- ☐ Adequate check on accuracy of information given to relatives, others.
- ☐ Dissemination of news to public (via radio and press) to reduce switchboard overload. (Public may ask how to make drinking water safe, how to prepare baby formulas, where to be inoculated, etc.)
- ☐ Locate administrator's emergency headquarters near information center.
- ☐ Have switchboard relay all inquiries from Civil Defense authorities, police, etc., direct to administrator's headquarters.
- ☐ Provision for relatives to visit morgue to identify disaster victims.
- ☐ Policing of entrances, corridors, grounds—to channel visitors and curiosity seekers to information center.
- ☐ Set up detention area for children separated from parents.

OTHER ESSENTIALS

- ☐ Coordination of plan itself with community-wide planning of Civil Defense, Red Cross, armed forces, police, town officials. (Experience indicates confusion invariably follows first alert; administrator must know who is in charge outside of hospital.)
- ☐ Distribute copies of hospital's disaster plan to all employes, staff doctors, neighboring hospitals, community officials, Civil Defense, Red Cross, police, volunteer corps, armed forces, etc.
- ☐ In addition to hospital master plan, develop detailed departmental plans. (Chief of staff to have overall charge of all medical, surgical, and evacuation activities.)
- ☐ Conduct periodic drills to test effectiveness of master plan.
- ☐ Investigate availability of government's 200-bed portable hospitals stockpiled for emergency use. (In the event of all-out bombing, atomic or otherwise, all surviving patients and staff members might have to be evacuated to some outlying district.)

Muscle Metabolism

FEW of us are aware of the myriad movements we make during our daily rounds. So smoothly do our muscles respond to the commands of our nervous system that we seldom become conscious of their activity; we take for granted the processes that make them function. Yet the way in which muscles work is a problem of enormous complexity that continues to baffle those seeking its solution.

Right now, however, hopes are high that recently developed research tools and techniques will uncover long-sought secrets. How muscular tissue converts the chemical energy contained in food into mechanical activity is one of the most fundamental problems in basic biology. Its solution is of practical importance to medical men, too; for health and happiness depend largely upon the efficient functioning of this tissue that makes up more than half the weight of our bodies.

Learning more about muscle mechanisms may save many lives. Such knowledge is needed not only in the treatment of comparatively rare neuromuscular disorders (such as myasthenia gravis and muscular dystrophy), but also in the battle against the much more common cardiovascular diseases; for the heart and blood vessels are made up of muscle cells that function in essentially the same way as those that bulge beneath the skin.

The human body contains three kinds of muscle. One variety is the "smooth" muscle of the stomach, intestines, and other internal organs, made up of sheets of spindle-shaped cells. The movements of these "involuntary" muscles are influenced by impulses carried over the autonomic nervous system from brain areas below the cortical level. Thus they function largely without either our awareness or our ability to control them.

The heart is made up of another variety of muscle—a mass of slender cells that branch off at angles and then reunite in an irregular pattern to form an enormous network of cross-connected fibers

by Morton J. Rodman

functioning as a single unit. The contractions and relaxations made by this powerful muscular pump as long as life goes on are largely automatic. Cardiac muscle has an inherent rhythm, a built-in beat regulated somewhat by nervous impulses but not controlled by them.

The third type of muscles are called "skeletal," because they are bound to the bones at each end, usually by tough tendons. It is the contractions of these muscles that move us about at will and let us make all our varied voluntary movements from the winking of an eyelid to the lifting of heavy weights.

Under the microscope, these muscles have a characteristic striated appearance and may be seen to be built of thousands of thin thread-like fibers packed side by side in long strands and lashed together to form firm bundles.

Submicroscopic studies show that each fiber is made up of elongated protein particles formed of long chains of atoms linked together into amino acid molecules. Water is trapped within this molecular meshwork to form an elastic gel of a tensile strength so great that its contraction can raise loads hundreds of times its own weight.

This viscous contractile compound is called actomyosin, a combination of two proteins, actin and myosin, briefly united by the nerve impulse initiating the contraction. Actomyosin packs more power than the most modern engines devised by man.

But what is the fuel for this muscular engine? Scientists are agreed that the chief source of energy for muscular contraction is an amazing compound, adenosine triphosphate, or ATP. This energy-rich substance in the muscle cells acts as a storage battery for the energy the body gets from food.

When the muscle cell is excited by a nerve impulse, ATP is brought briefly in contact with actomyosin, causing its atoms instantly to curl up on themselves. It is this sudden shrinkage of the muscle protein that accounts for its powerful con-

traction. During the relaxation period, the energy lost in the brief breakdown of ATP is replenished by the burning of glucose in a series of enzymatic reactions requiring oxygen.

The energy released by this oxidative breakdown of simple sugars is packed back into the chemical bonds by which phosphate groups are once more tied to ATP; the muscle cell is then ready to contract again.

Sometimes, however, during an excessive expenditure of energy, muscles may need more oxygen than the blood can carry to them from the lungs. In such circumstances, the muscles may work for a while without oxygen by means of another mechanism. But, in the end, the body must pay back its "oxygen debt." Fatigue then forces the body to rest and take on the oxygen needed to replenish the cells' store of ATP. In death, when the metabolism of sugar has stopped forever, ATP can no longer be built up as it breaks down. As a result, the muscles harden into *rigor mortis*.

Muscles sometimes fail to function properly due to some slight disorganization in the complex series of electrochemical events by which the muscle fibers are fed and activated. Lack of a single enzyme may interfere with the nutrition of the muscle cell or with the passage of the nervous message that ordinarily commands the muscle to contract.

One such condition is muscular dystrophy, a progressive muscular disease for which no cure is known. In this condition, from which more than 100,000 U.S. residents suffer, healthy muscle fibers are destroyed and replaced by fatty tissue. Several different forms of the disease exist, including one that affects children between ages 3 and 12. Few of these youngsters ever live to reach their teens. Most die of suffocation when their weakened respiratory muscles fail to fight off lung infections. Other forms of muscular dystrophy hit adolescents and young adults who may not be crippled or killed until later in life because of the slower rate at which their muscles degenerate.

While the exact cause of the wasting away of once-sturdy muscles is not known, dystrophy is believed to be due to a defect in the processes by which muscle tissue is built up and maintained.

Some specialists believe, for example, that the muscular degeneration is due to a lack of vitamin E. Though this vitamin may not be lacking in the patient's diet, he is somehow unable to utilize it in muscle metabolism. Possibly a genetic lack of a key enzyme keeps the vitamin E from being converted into the particular product needed in building normal muscle. While muscular dystrophy is frequently found to follow a hereditary pattern, the exact inborn error in metabolism has not yet been definitely determined.

Many attempts have been made to overcome the condition by nu-

tritive measures. Unfortunately, the first favorable reports have generally been followed by doubt and disillusionment. Thus, while vitamin E protected animals from developing degenerative muscle changes similar to those seen in humans, the vitamin has been generally unsuccessful in improving or arresting muscular dystrophy. It is now hoped that some slight change may be made in the molecule of vitamin E that will give the new compound the biological activity the parent compound lacks.

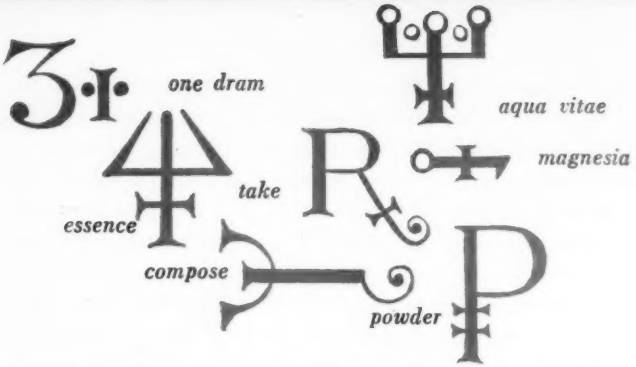
Another new treatment calls for the feeding of a formula containing twenty-two amino acids, together with essential vitamins, on the theory that the disease is due to one of two types of biochemical deficiencies. First, there might be a digestive difficulty preventing proteins from being split into all the amino acids. Or, if proteins were normally digested and absorbed, the lack of some co-enzyme (vitamins act as co-enzymes) might interfere with the assimilation and synthesis of the amino acid building blocks into muscle proteins.

While a few patients have improved under this regimen, the results are admittedly preliminary

[*Continued on page 76*]

PROBIE

"ONE BUBBLE-GUM, ONE SLING-SHOT, ONE—EEK!"



EDROPHONIUM CHLORIDE N.N.R. (*Curare Antagonist*)

PROPRIETARY NAME: Tensilon Chloride

PHARMACOLOGY: Edrophonium chloride stimulates the motor end-plates of skeletal muscle directly and, in part, by an anticholinesterase action. These actions account for its effect as an antidote against partial paralysis resulting from overdosage with certain curariform drugs. The drug is useful in the differential diagnosis of myasthenia gravis. In the latter condition, it produces an increase in muscle strength; in non-myasthenics, it may cause fasciculations, or twitching, of the muscles without increasing their strength.

DOSAGE: As an antidote to curariform drugs, edrophonium is given intravenously in doses of 5 to 10 mg. As a diagnostic agent, 2 mg. by vein is recommended, to be followed by another 8 mg., if the first dose elicits no reaction in 30 seconds.

UNTOWARD ACTIONS: Mild muscarinic effects, including sweating and blurring of vision, may occur. High overdoses may paralyze skeletal muscle.

VITAMIN E (*Vitamin Therapy*)

PROPRIETARY NAME: Marketed in various forms.

PHARMACOLOGY: The vitamin appears to have no pharmacological actions of its own, nor is there any evidence that it is required in the diet of humans. However, dietary deficiency of vitamin E in animals leads to abnormalities of skeletal and cardiac muscle and of the nervous and reproductive systems. Because many signs of deficiency resemble various clinical conditions, including muscular dystrophy, habitual abortion, and cardiovascular disease, vitamin E has been tried in their treatment. There is little evidence, though, that vitamin E is effective in these or other conditions.

DOSAGE: Doses vary considerably in different conditions. The daily dietary intake is about 30 mg., but doses up to 400 mg. of pure synthetic alpha-tocopherol are sometimes administered.

UNTOWARD ACTIONS: No specific toxic effects have been observed.

DRUG DIGEST

PYRIDOSTIGMIN BROMIDE (*Cholinergic Agent*)

PROPRIETARY NAME: Mestinon Bromide

PHARMACOLOGY: This new cholinergic drug is said to be more effective than neostigmine in the treatment of most myasthenics. Because the effect of each dose taken during the day is partly cumulative, the drug appears to permit most patients to sleep through the night without needing further medication until morning.

DOSAGE: Dosage must be adjusted to meet the needs of each patient individually, and should be increased only slowly to prevent side effects. A 60 mg. tablet is about equal to 15 mg. of neostigmine.

UNTOWARD ACTIONS: Gastrointestinal side effects, including abdominal cramps, nausea, and diarrhea, are said to be minimal. However, high overdosage could cause these and other cholinergic effects, including salivation, sweating, and lacrimation. These parasympathetic side effects can be reduced by administration of atropine.

ZOXAZOLAMINE (*Muscle Relaxant*)

PROPRIETARY NAME: Flexin

PHARMACOLOGY: Zoxazolamine is a recent adjunct in treating conditions characterized by spasticity of skeletal muscles. The drug depresses the central nervous pathways by which excessive numbers of motor impulses are transmitted to muscle. It is claimed to have a longer duration of action and greater effectiveness by oral administration than mephenesin and other centrally acting agents; it is safer than d-tubocurarine and other curariform drugs that act directly at the motor end-plates of muscle.

DOSAGE: Oral doses of from 2 to 6 Gm. daily have been employed; patients have showed objective improvement on doses of 250 to 500 mg., one to two tablets, three and four times a day, with meals or food.

UNTOWARD ACTIONS: Side effects, said to be relatively mild and readily controlled, include nausea, epigastric pain, dizziness, and drowsiness.

Miss Nightingale's Personality

by Werner K. Gottstein*

FEW women of Victoria's day—including the Queen herself—were accorded greater acclaim than Florence Nightingale (1820-1910); in fact, the story of her life is now so well known that all would still recognize her as one of history's outstanding humanitarians even if she had never been immortalized as the Lady with a Lamp in Longfellow's "Santa Filomena." Yet despite the voluminous writings of her biographers, her personality remains something of an enigma. . In an individual of Miss Nightingale's stature, it would be futile to attempt a personality study from the viewpoint of modern psychoanalysis. No mere grouping of her subconscious reactions and frustrations would do her justice. In any event, it is certainly more appropriate to understand with deep reverence her inner sufferings and conflicts.

Born of wealthy English parents and raised on her father's country estate, she was a sensitive child. In her memoirs she remembers having had a mortal terror of speaking to other children and of doing anything that would stamp her as "different" from them. She also admits that she was given to constant day-dreaming.

From both parents, Florence inherited exceptional vitality. Her father—a master of foreign languages and well versed in the classics, who taught her, among other things, Greek, Latin, and mathematics—lived to be 80 and her mother to be 92. Yet neither they nor any of her long-lived ancestors led as strenuous a life as Florence herself; she attained, nonetheless, the age of 90 in a era marked by frequent epidemics.

When such constitutional vitality is paired with unusual intelligence and deep-seated emotions, the years of adolescence and inner maturation cannot be easy. That they weren't for young Florence is apparent from the record of her active years. She was high strung, subject to "nervous breakdowns," and was driven almost to suicide by her inner conflicts.

Her introspective attitude during childhood carried over into her formative (and later) years. She preferred solitude and meditation

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—despite occasional outpourings to her understanding friends and cousins.

Any young woman, of course, has her own good reasons for wishing to be left alone. In Florence's case, the reasons were many. As a teen-ager, she had traveled with her family through France, Italy, and Switzerland for a year and a half; social conditions there could hardly have escaped her notice or failed to have made a lasting impression on her youthful mind. Her solitude, therefore, was justified when she approached the problem of what to do with her life and how best to be of service to mankind.

Her decision was unquestionably influenced by the fact that she had become increasingly disgusted with the superficiality of English social life. Her youthful beauty as well as her family's wealth made a life of leisure and gaiety the obvious choice; but inwardly she detested the idea of becoming what today we would call a "social butterfly." It took courage—and solitude—to choose as she did; and when she finally announced her intention to nurse in the London slums, her parents were deeply shocked.

Another reason for her meditative nature was an inborn tendency to mysticism, inherited from her father's side of the family, along with an inherent wish to shun publicity. Mysticism is the deep spiritual union with the power of eternity; and one overwhelmed by this

Florence Nightingale

insight will not pay tribute to the evanescent enthusiasm of public recognition. With Florence, this inborn tendency was nourished and strengthened by her perusal of contemporary literature.

Love, too, played its part in her leanings toward solitude; and while one is never under the impression that she suffered excessive heartbreak from this cause, she is known to have turned down several suitors from high society who were desperately in love with her. One, Monckton Milnes, a famed Yorkshire squire and first biographer of the poet Keats, ardently courted—and nearly married—the attractive Miss Nightingale. But by this time, she believed too strongly in her own mission,

though her family preferred her to live a more conventional life. Like Cassandra, daughter of Priam, King of Troy, who predicted the danger of the Trojan horse, Florence prophesied the futility of a self-complacent existence without devoted action.

Friction in the family, serious though it must have been to young Florence, was nothing compared to the later obstacles that had to be surmounted by the force of her personality. Her years of nursing were well marked by active and passive resistance from military organizations, physicians, nurses, and members of Parliament.

During the war in Crimea, as well as in peace time, she suffered from nervous insomnia. At Balaklava, where she attended the wounded on the battlefield, she remained on duty until she collapsed —a victim of "Crimean fever."

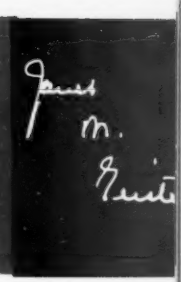
On her return to England, she was slated to receive triumphant acclaim as a national heroine. The public, calling her "Commander-in-Chief," was well aware that, prior to her arrival at Scutari, army losses from cholera, dysentery, hunger, rat-infested barracks, and inadequate clothing had exceeded battle casualties. Military physicians, once opposed to women nurses among their men, now spoke of Miss Nightingale as one of God's most gifted creatures. Even her family, previously determined to ostracize her because no respectable gentlewoman should lower herself to nurse dying prostitutes in a hospital for the poor, stood ready now to welcome her and share the limelight that was due to be hers.

But Florence, unlike some of her modern sisters, never made a public appearance. Unannounced and unheralded, she returned to the

[*Continued on page* 80]

How many do you recognize?

CANDID COMMENTS



The Meaning of the Lamp

Two motivating forces in Florence Nightingale's character explain why she stood out, head and shoulders, above the crowd. One was her *humanity;* she cared deeply, passionately, and everlastingly about people and their well-being. Her written words are centered around the needs of patients; her daily life, in small and great acts, was given over to doing something about those needs. She had a penetrating mind, sound common sense, and an exquisite sensitiveness to the dignity and God-given rights of every man. These qualities were fused with an abiding compassion that stirred her to militant action.

Humanity, however, is not enough. Many people care what happens to others, but they haven't enough moral strength to back up their concern with action, especially if their own interests are involved. Miss Nightingale's other great force was *courage;* the two forces went hand in hand, for the courage rose out of the depth of her humanity. She had recognized a great need; the wounded soldiers in Crimea were shockingly neglected, and their death rate was a disgrace. Something had to be done. But that something meant fighting entrenched tradition, military rigidity, and bureaucratic blindness—which, among other things, made it unthinkable for a gentlewoman to go to the battlefield.

I like to read again and again of her battles and victories. By day she could stand up unflinchingly to the blustering generals; at night, carrying her precious candle, she could speak tenderly to a dying man, or write a letter for him to his family. There was magnificence in the quality of her sympathy, and in the courage she put behind it. She was no saint; the historians list some earthly faults, but the greatness of her love and the strength of her moral fiber far transcended what human frailties she had.

Miss Nightingale became a leader, but she didn't start out to be one. I doubt if the thought ever entered her mind, or if it enters the minds of any of the people whose leadership lives through the centuries. It was my rare luck as a young nurse to come under the influence of Jane Addams, Julia C. Lathrop, and Ella Phillips Crandall, all of whom have left deathless legacies in better lives for people. There wasn't an "I" in their vocabularies, much less in their minds. (Someone compared the number of "I"s in Miss Addams'

"ZEKE AND DESSIE"

book *Twenty Years at Hull House* with those in the book of a contemporary; the ratio was one to ten.) The leadership of these women was not a calculated one; rather it had sought them out, because their humanity and courage had made them big.

It has been said that it took several generations to produce an Abraham Lincoln. This can be said as well of Florence Nightingale. But our great need today is not for a single, outstanding voice, but for a chorus of voices. Nursing now reaches into every realm of human activity; it has a position of authority in the health care of people. Nurses are touching more lives than ever in history. There must be in every nurse certain qualities of leadership.

Functioning as adults with adult responsibilities, we need to demonstrate to ourselves the ability to do our own thinking. Functioning as practitioners in hospitals and community, we have to lead and teach, as well as *do*. Through our experiences and thinking we lead our employers and fellow workers, as well as our patients. And we teach more and lead better by our attitude, conduct, and integrity than by what we say.

True leadership begins in the heart. It has nothing to do with headlines or being listed among the

very important people—though the VIP's include some who are true leaders. Again and again I've gone into homes where family life has been enduringly bettered by the leadership of nurses who cared enough and had courage enough to

follow through, regardless of tough obstacles. In industry, as well as in schools and hospitals, we see nurses lead patients not only to better health but to productive lives. The grass-roots leadership of nurses who care and who have courage is the very foundation of nursing.

But as we all need qualities of leadership within ourselves, so must we also have abilities to follow. Wherever people work together there must be leaders; a leaderless group is an aimless group. The instinct to accept lead-

ership is ingrained; all of us look to our teachers or preachers or elected or appointed officers to guide us. "It is ingrained even among animals," says my farmer friend. "When I sold the cow that always led the others in, the other cows were at first bewildered; but in a few days they had selected a new leader, a steady old girl who can always find the best grass. It's that way with the sheep, too, and I suppose with people; only I often think the animals show the best sense."

As the health hungers of our people grow, and as modern practices demand closer team-play among health workers, nursing is steadily being drawn into a vortex of new fields, new responsibilities, new relationships. Our major problems are not self-contained; they reach into the problems of others. Hospital nurses' salaries, for example, are tied in with the hospital's allocation of dollars; and this, in turn, is tied in (at least in part) with hospital-medical relationships. Too, many professional tasks involve questions concerning the le-

gal practice of medicine: Shall the educator prepare nurses for these tasks before nurse-practice laws are amended to give nurses legal authority to do them? Can these laws be amended without the approval and support of doctors and other allies?

Problems of this nature are growing. They call not for supermen but for better leaders and followers. Events have changed the relationship between these two groups; the individual must take a more responsible place in the councils and in formulating opinion. The leaders lose no prestige or power, but no longer are great distances tenable between them and their followers. Rather there is gain in this circumstance, as decisions based on a clear knowledge of what followers think are better than those based on guess work. Early in my experience in our nursing organizations, I used to be shocked when board members would announce authoritatively, "Now, the nurses want . . . "; for these board members might have lived at the North Pole for all they knew of rank-and-file thinking.

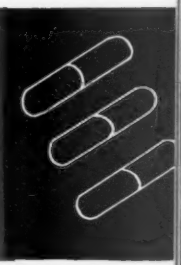
The spirit of our leadership today is of transcendent importance. The lives of people, the good of the profession, and the welfare of nurses are all affected by the decisions of those with power for action. Scores of books and articles are written on leadership, but our concern here is not with qualifications and techniques, but with the spirit that underlies and permeates them. When a young woman anxious to be a writer asked me for help, I said to her what I've said to others, "Yes, techniques and style are important; but the first essential to worthwhile writing is to *have something to say*, and want awfully to say it." Sound preparation and wide experience are the ingredients of real leadership; but it's only when the individual has "something to say and wants awfully to say it" that they make a leader.

I've often wished we could look into the hearts and minds of candidates for leadership posts, as well as look at their educational and experience records. There's a wide difference between a calculated leadership, born of personal ambition, and a natural one, like Miss Nightingale's, born of a love for people. Helen Hayes, paying tribute to the late Gertrude Lawrence, said, "The difference between a fine actor and a star is a great heart . . . The star has a love for people."

But again, love is not enough. There must be courage, too—courage to stand up, even if alone, for one's convictions. We live in an era of conformity—and conformity doesn't necessarily require courage. The rugged individualism that characterized much of the early discussions of our leaders has given way to "cooperation." Cooperation has distinct advantages; but it also carries the danger of "going along" with the majority, despite convic-

[*Continued on page 84*]

NEWS CAPSULES



NEWS More than 400 nurses, some from distant points in the Midwest and Canada, attended the recent regional meeting of the American College of Surgeons in Philadelphia, marking the second successive year in which special programs have been arranged for nurses at an ACS gathering. A symposium on the management of mass casualties, together with panel discussions covering the nurse's role in disaster planning, were among the featured events of the four-day sectional meeting.

NEWS The Commission on Chronic Illness, incorporated in 1949 as a temporary organization, will terminate its activities on June 16. Its bi-monthly news letter is now being published by the Council on Medical Service of the American Medical Association.

NEWS In-service education for the improvement of patient care in Army hospitals was the featured topic at April's conference of chief nurses, conducted by the Army Medical Service in Washington, D.C. Several educators prominent in the civilian nursing field took part in the Washington conference.

NEWS A six-year study of the nursing curriculum at five Atlanta (Ga.) hospital schools is being undertaken with a grant of $331,545 ($46,575 of it in 1956) from the U.S. Public Health Service. The project is being supervised by a committee representing the schools and the Georgia State College of Business Administration. Study details are being conducted by Couey and Couey, educational consultants. The schools are those of the Crawford W. Long Hospital, Georgia Baptist, Grady Memorial, Piedmont, and St. Joseph's Infirmary.

NEWS An 80-page "Program Guide for Future Nurses Clubs" is being circulated in the nation's high schools by the Committee on Careers, National League for Nursing, which has assumed sponsorship of the rapidly growing movement. At last count, some 1,400 such clubs had been organized among teen-agers.

NEWS Physical therapists, nurses, and other health specialists from twenty countries are expected to attend the second congress of the World Confederation for Physical Therapy at Hotel Statler, New York City, June 17-23. Listed speakers include Drs. Thomas Francis, Jr., Howard A. Rusk, and Henry H. Kessler. Topics include research and new techniques in prosthetics, health aspects of pos-

ture, underwater exercise, devices for neuromuscular disorders, testing and evaluating procedures, community rehabilitation programs, and use of physical therapy in polio, cerebral palsy, and thoracic surgery.

NEWS Loretto Hospital, Chicago, has instituted an in-service training program for all employes in an effort to increase efficiency and thus reduce patients' bills. A firm of efficiency experts has been hired to conduct the program, which is being financed in part by a grant of $77,900 from the Ford Foundation.

NEWS Alumnae of the Jersey City (N.J.) Hospital School of Nursing donated $500 recently to the Medical School of Seton Hall University.

NEWS American Nurses Association has announced the following slate of candidates for election to office at the mid-May biennial: *For president:* Agnes Ohlson (incumbent), Hartford, Conn.; Dorothy C. Lowman, Salt Lake City. *For first vice-president:* Mrs. Myrtle H. Coe, Minneapolis; Mary C. Walker, Denver. *For second vice-president:* Louise Knapp, St. Louis; Mathilda Scheuer, Philadelphia. *For third vice-president:* Henrietta Doltz, Portland, Ore.; Lucy D. Germain, Detroit. *For secretary:* Julia M. Carnahan, New Orleans; Frances L. A. Powell, Chicago. *For treasurer:* Thelma Dodds, St. Paul; Alice Topzant, Milwaukee. *For membership on ANA Board of Directors:* Agnes E. M. Anderson, Orlando, Fla.; Margaret Filson, Chicago; Evelyn M. Hamil, Hondo, Calif; Virginia A. Jones, Honolulu; Faye Pannell, Dallas; Miriam Robider, Baltimore; Sister M. Theophane Shoemaker, Santa Fe; Helen J. Weber, Bloomington, Ind. *For membership on Committee on Nominations:* Frances H. Cunningham, Cleveland; Mrs. Catherine Gehrman, Omaha; Alice C. Hale, Butte, Mont.; Albert Launt, Binghamton, N. Y.; Amelia Leino, Laramie, Wyo.; Mrs. Ruth B. Selby, Philadelphia; Alberta Trunck, Wilmington, Del.; Flora R. Wakefield, Raleigh, N. C.

NEWS For the third successive year, the University of Maryland School of Nursing has been granted $12,000 by the Commonwealth Fund for graduate-study scholarships leading to an MS in psychiatric nursing.

NEWS Federal Trade Commission is currently investigating consumer prices of antibiotics and other expensive drugs, according to *Washington Report on the Medical Sciences.*

NEWS Third annual conference of the Association of Operating Room Nurses, held recently in Boston, was attended by some 1,400 surgical-minded nurses and 200 guests. Highlights of the three-

day sessions included panel discussions on disaster planning, aseptic technique, teamwork, and clinical instruction of student nurses. Also featured were a "problem clinic" and a demonstration of how a reconstructive surgical team functions.

NEWS Organized nursing has endorsed, and organized medicine has opposed, the proposed revision in the Social Security Act which would permit totally disabled workers to collect benefits at age 50. Another provision of the bill, which would lower the retirement age for women from 65 to 62, has also received official sanction of the American Nurses Association.

NEWS A history of nursing in Missouri is being compiled by Edwin A. Christ, sociologist at the state university, under a grant of $5,515 from the Missouri State Nurses Association.

NEWS *Marian Alford*, NLN's director of hospital nursing, has been named executive director of the California State Nurses Association . . . *Alma C. Haupt*, an authority on public health nursing and prior to her retirement in 1953 director of nursing for the Metropolitan Life Insurance Company, died suddenly on March 15 in San Francisco . . . *Maxine Atteberry* has been appointed dean of the College of Medical Evangelists School of Nursing, Los Angeles . . . *Shirley Thompson* has been named director of nursing service at the new University of Oregon Medical School Hospital, Portland, Ore. . . . *Mrs. Mildred Barcal Fernandez* has been elected president of the Louisiana League for Nursing . . . *Dr. Marie H. G. Charlier*, founding vice-president of the New Jersey Academy of Science and a former R.N. contributor, died recently . . . *Elizabeth Cain*, only surviving member of the Class of 1907 at St. Mary's Hospital, Milwaukee, was recently reported to be still doing active duty, full time, at St. Mary's, where she has worked regularly for forty-nine years . . . *Martha D. Adams* is the new president of the California League for Nursing . . . *Florence Kempf*, dean of the school of nursing at Michigan State University, has been named a member of the state nursing board to succeed *Ella Mae Murdie*, who resigned.

NEWS Studies in patient care were conducted in fifty general hospitals in New York, New Jersey, Ohio, Indiana, Michigan, and Illinois during March and April to determine (a) to what extent the number of hours of nursing care given a patient contributes to his satisfaction, and (b) what nurses and other staff members think about the nursing service provided. The studies were sponsored by the American Hospital Association and the U. S. Public Health Service, with Faye G. Abdellah, R.N., Ed. D., as project director.

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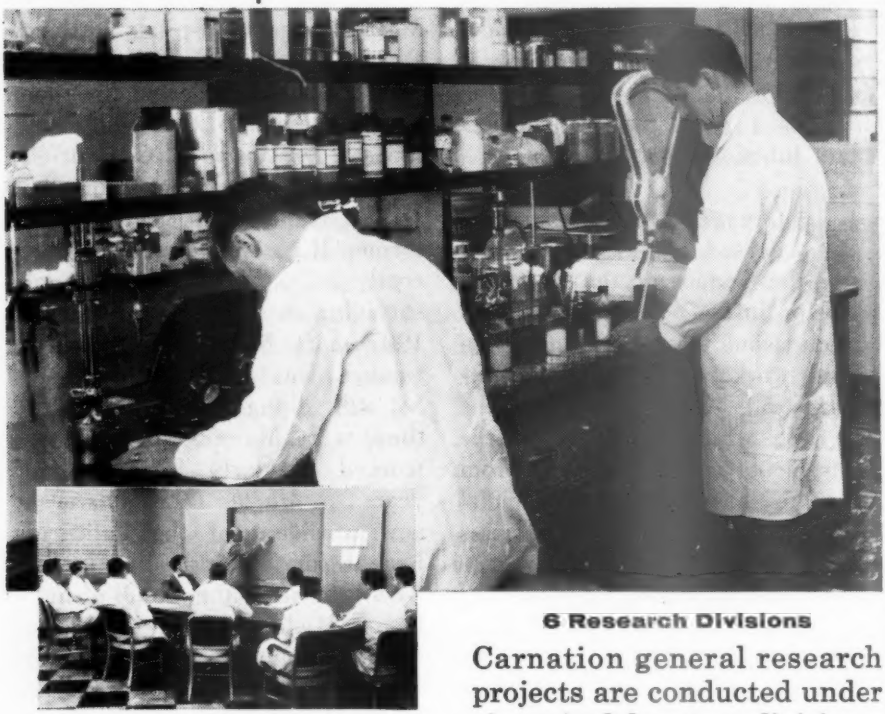

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"from Contented Cows"

[*Continued from page* 35]

mouth . . . a beautiful young girl, burned everywhere except the face, lay in a puddle of blood and pus. A soldier, naked except for shorts, lay on a mat smeared with blood. Others wore improvised articles of clothing made from curtains, tablecloths, or any other materials their friends had been lucky enough to pick up around the hospital.

Emotions—

Parents, half crazy with grief, searched for their children. Husbands looked for their wives, and children for their parents. One poor woman, insane with anxiety, walked aimlessly here and there through the hospital calling her child's name. Another woman stood at the entrance, shouting mournfully for someone she thought was inside . . .

What a weak, fragile thing man is before the forces of destruction. After the *pika* [flash] the entire population had been reduced to a common level of physical and mental weakness. Those who were able walked silently towards the suburbs and the distant hills, their spirits broken, their initiative gone. They were so broken and confused that they moved and behaved like automatons.

Outsiders reported with amazement the spectacle of long files of people holding stolidly to a narrow, rough path when close by was a smooth, easy road going in the same direction.

The Doctors—

Eighty doctors out of 190 in Hiroshima were killed by the *pikadon* [flash-boom], and many of them had been my friends . . .

Ever since the blast the screws of our hearts had been loose, but Dr. Norioka was tightening them up with his silent virtues. He worked hard. He was a man who noticed everything. Above all, he had sympathy and discernment, and he found time to teach us as well as to treat us. For the first time since the bombing I felt that we were beginning to catch up.

The Staff—

All the staff were wounded, but despite their wounds, they fought courageously. Through the excitement and commotion they were the epitome of brotherly calmness and coolness. Even though enured to death and disaster, I was amazed at their calmness and coolness . . . During the critical period I only wished I could have shown the same calm the nurses expressed . . .

On a bench in front of the janitor's room I found one of our nurses staring blankly into space. She had been working night and day without rest. She looked tired and worn and had lost weight. It was girls like this and others in the hospital, working inconspicuously, who had held things together.

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References: 1. Illinois M. J. *105*:305 (June) 1954. 2. Obstet. & Gynec. *1*:94 (Jan.) 1953. 3. Bull. Margaret Hague Maternity Hosp. *6*:107 (Dec.) 1953. 4. Missouri Med. *51*:727 (Sept.) 1954. 5. J. Michigan State M. Soc. *53*:862 (Aug.) 1954.

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THE SURGEON

[*Continued from page 39*]

tonitis will localize somewhere, to be drained later.

Some of you may have heard about the professor of surgery at Nagasaki who was twenty miles outside of town when the bomb went off. With great difficulty, the professor walked to town and went to work, operating. By morning, his post-operative patients were dead. Then he went outside the hospital and began to do some real good. By using simple, surgical procedures, he did the best for the most.

It's up to all of us to study the effects of ionizing radiation of atomic explosions, the radioactive fall-out materials, and therapy of radiation injury. In fact, we must keep abreast of all scientific advances that will improve the care of disaster-wounded, and urge widespread adoption of such preventive measures as immunization against tetanus. It's been said that he who ignores the past must be prepared to repeat it. Apparently, one lesson that we've failed to learn is that excision or debridement is necessary to prevent life-endangering infections.

The ground rules are here for all to see. We must spread the message of preparedness—of training, of planning. If the bomb comes—as it did in Nagasaki and Hiroshima—we want to be ready. For every doctor will have to shoulder a staggering burden of casualties.

PSYCHOLOGICAL

[*Continued from page* 44]

some part of his body has stopped functioning. Such casualties are not malingering; they are just as disabled as though they were injured physically.

Although you probably can't relieve such symptoms immediately, you can show an interest in these people. You may even give them tasks that they can perform with their disability. In this way, you help them to regain their composure gradually.

Elderly persons and children offer special behavior problems during a disaster, but both groups generally respond to quiet, understanding supervision. However, the aged may not respond as quickly as the young or middle-aged—they're apt to be more confused.

The three most important principles in handling mental casualties are:

Decentralization or peripheral treatment. Persons with temporary emotional disruption should be treated as far forward and as soon as possible to prevent later complications. Hospitalization is more likely to prolong emotional disorders. Early at-the-scene treatment also ensures more manpower for essential disaster duties.

Expectancy. In handling individuals with behavior disturbances, you must expect and believe that they will get better. If you express fear or apprehension, either verbally or non-verbally, victims be-

come much more fearful themselves.

Simple therapy. Complicated treatment, involving electroshock, drugs, etc., destroys the benefits derived from "decentralization" or "expectancy" by convincing these people that their condition is serious. The best therapy is a brief respite of five to ten minutes in which individuals can ventilate, or talk about the horrible things they have seen. If you can listen without interruption, you open up their communication system. And once this is done, they can be given work under supervision, for at this point they're like frightened children who have to leave their mother.

It's well to remember that medical personnel will also create problems, and have psychological difficulties themselves, particularly if they have no disaster training to fall back on. It's not unusual to see untrained volunteers rush into disaster areas and act in frantic, unreasoning haste. A common mistake of such well-meaning "do-gooders" is to speed victims to a distant hospital when they should be cared for on the scene.

According to psychiatric authorities, training is the only answer to prevention of non-effective behavior and the key to the handling of mass casualties. Disaster training, including drills, practice runs, etc., gives us the benefit of responses that rouse us to appropriate and effective action at the moment of impact. Such automatic responses are essential to our survival as well as the survival of others.

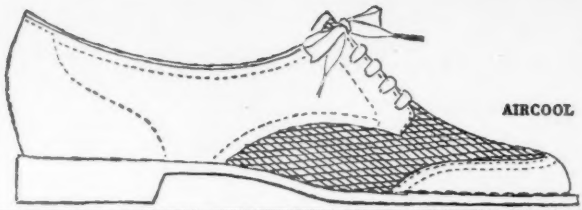
THE NURSE

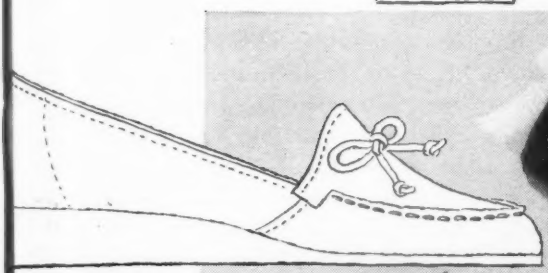
[*Continued from page* 46]

the care of unconscious patients, etc. To prepare for emergency regrading or upgrading of nursing functions, surgical subjects might include: wound closure, debridement, amputation, chest aspiration, etc. Practice is needed, too, in managing large wards.

Also, we musn't forget the need for intelligent organization of nursing service. Our plans must be flexible, for casualties do not all arrive at once. Key staff members must know where to obtain help if the work load in one area becomes too heavy; provision must be made for meal time and rest periods. Above all, practice runs should be arranged so that persons will develop proper team relationships as well as learn their primary and secondary roles. Secondary roles assume great importance when you realize that some of the staff will, themselves, be casualties or may not be able to get through to their stations.

Actually, these expanding functions should not be too difficult for nurses. In planning for the care of mass casualties, nurses are only being asked to move along from the simpler to the more complex tasks. And the only reason for this proposed change in the fine boundary line between nursing practice and medical practice is to help our doctors give the best care possible to the greatest number.





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MUSCLE METABOLISM

[*Continued from page* 55]

and are not yet supported by any biochemical evidence of beneficial changes in body chemistry. In any case, such therapy would be no cure, but only an attempt to replace temporarily some ingredient missing from the body's muscle-making machinery.

Another neuromuscular disorder, myasthenia gravis, is somewhat less mysterious. Recent research has revealed some of the factors involved in this disease; and new drugs have been developed to control the symptoms of most victims.

Myasthenia means a weakness of the muscles; indeed, the condition is characterized by the ease with which the skeletal muscles become fatigued and exhausted. But in myasthenia gravis the loss of muscle strength is not caused by any wasting of the tissues; it is due to a difficulty in transmission of the nerve impulse from the ends of the motor neurons to the skeletal muscle fibers.

Recent research has revealed the complex train of electrochemical events that occurs when a nervous signal arrives at the myoneural junction. The arrival of the impulse at the motor end-plates of muscle causes the release of the neurohormone, *acetylcholine*. This substance sets up a state of excitability in the muscle fiber by briefly disturbing the electrochemical balance of its membrane. Acetylcholine itself is immediately destroyed by *cholinesterase*, an enzyme concentrated at the end-plates. This breakdown of the hormone serves to prepare each end-plate to receive and transmit the next impulse. Then, acetylcholine itself is reconstituted and readied for the next firing by means of a chemical reaction requiring still another enzyme, choline acetylase, and the cellular sparkplug, ATP, which furnishes the energy for the reaction.

Obviously, any breakdown in this exquisitely synchronized series of reactions, which must follow within milliseconds of one another, will interfere with neuromuscular transmission and lead to a loss of contractility. The cause of myasthenia could be (a) an impairment in the synthesis and release of acetylcholine, or (b) an excess of cholinesterase. But recent evidence indicates that it may lie in the body's production of a substance that dulls the ability of the end-plate to respond to stimuli, in much the same manner as does the paralyzing drug, curare.

In any case, decurarizing drugs often bring about a dramatic reversal of the muscle weakness of myasthenia. The most successful drugs are the "anticholinesterases"—agents that act by temporarily tying up the enzyme, cholinesterase. This permits acetylcholine to pile up at the motor end-plates and exert a more powerful and prolonged effect. Unfortunately, these drugs sometimes cause side effects

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(such as salivation, sweating, nausea, and diarrhea) due to the simultaneous stimulation of nerve-impulse transmission at the myoneural junctions of certain smooth muscles and at the secretory cells of some glands.

Newer drugs have been developed recently to lessen such side effects. One cholinergic chemical, edrophonium (Tensilon), seems to cause fewer untoward reactions than the older drugs, physostigmine, neostigmine, TEPP, and OMPA. However, because of the brevity of its action, edrophonium is employed mainly for differential diagnosis of myasthenia gravis rather than for treatment.

Two longer-lasting drugs, said to cause considerably fewer side effects, have been introduced recently. These drugs, pyridostigmin (Mestinon) and ambenonium (Mysuran), seem safer and more effective than the earlier drugs. But neither is a cure for the condition. As in muscular dystrophy, the real answer lies in future research.

Such research may pay unbelievably rich dividends in the alleviation of human suffering. For the findings could be useful, not only against neuromuscular disorders, but also in other conditions in which muscle weakness or spasm play a part. Heart disease and hypertension, two of our most common killers, could be conquered, perhaps, if research could uncover the basic defects in the body's muscle metabolism.

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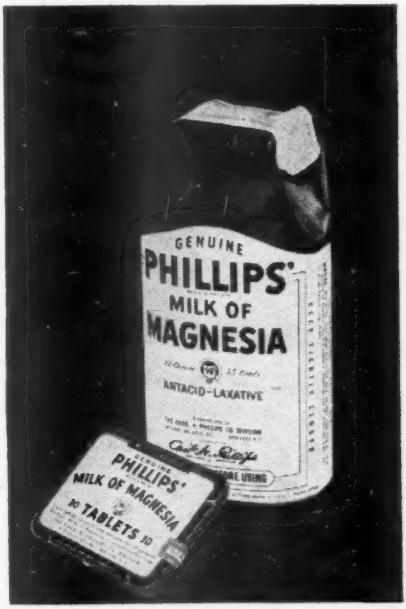

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MISS NIGHTINGALE

[*Continued from page* 60]

family home—and didn't confide in anyone. Her mind was filled only with that which appeared essential to her. She thought, as she expressed it, of her "nine thousand children" lying in forgotten graves from causes that might have been prevented. She thought of the many soldiers who "enlisted only to die in polluted barracks." In desperate retirement, she prepared her "Notes on Matters Affecting the Health, Efficiency, and Hospital Administration of the British Army." This report, published in 1857, initiated a new era.

Her escape from publicity cannot justly be attributed to her complete physical exhaustion; those vain by nature are revived by public acclaim and applause. The psychological root of her reticence lay in her earlier meditations and the reasons she had for being so introspective.

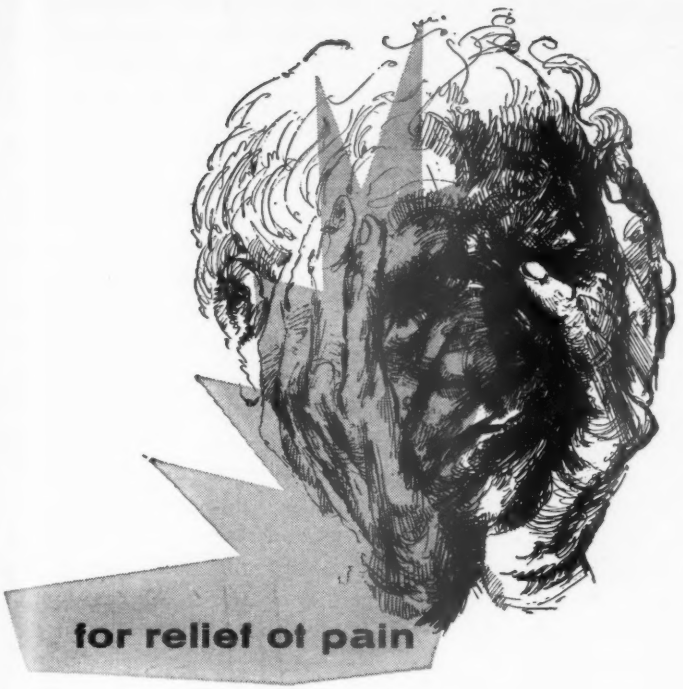
In this connection, I would call your attention particularly to her letters to Mary Clarke and her privately printed "Cassandra" diary. Her letter on the "Reality of the Unseen World" is not only deeply religious and philosophically profound but poetical; and the diary becomes a document of almost cynical despair when she mentions the vacuity and boredom of her drawing-room existence at age 32.

None of us can develop character by introverted meditation

alone; voluntarily or otherwise, we are influenced by our environment. Conditions about us may be so strong that we succumb to them, and this was often the case in the proletarian homes of nineteenth century England. Relentless class distinctions prevailed, as we know from Dickens' *Oliver Twist* and *David Copperfield*. But young Florence could choose among a great variety of environmental influences. Nothing that money could buy would be denied her—provided it did not jeopardize the social standards of the family and the rigid rules of etiquette.

As far as etiquette was concerned, Florence was no *enfant terrible*. Her charm, her dress, her smile, and even her dancing enchanted the most conservative among the Victorians. And though outwardly she appeared vivacious at social functions, a schedule of fun was merely a temporary compromise; it did not fully occupy her mind. More important to her was what we would now term "contact" with the less fortunate; and it is in this urge that we encounter the real personality of Miss Nightingale.

Her meditations as revealed in diaries and letters might lead us to believe that she was only an introvert; but her contacts with people prove she was quite the opposite. In choosing to nurse the needy, she plainly selected those influences that satisfied her logical, mathematical, and humanitarian inquisitiveness.



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SQUIBB

CANDID COMMENTS

[*Continued from page* 64]

tions. I always remember the words of a man of wisdom: "When harmony comes in at the door, progress flies out of the window." Minority opinion is very essential to progress.

Vivid in our memories are many nurses who have passed on, who never attained high position or made the headlines. But in their spirit of leadership, in their humanity and their courage, they were kin to the very great. I like to think about them and their enduring influence on the lives of people and the character of nursing. They have many counterparts in our ranks today—young men and women with the same inspiring qualities. These are the people we must seek out when we are choosing leaders for today's challenging scene.

The deathless army of Florence Nightingale marches on. Today, tomorrow, and in other tomorrows, nursing students will get their caps in singularly moving ceremonies. They will repeat the Nightingale Pledge—and, in a high moment of dignity and solemn meaning, they will light their lamps in a renewal of faith in the principles that have made Florence Nightingale a symbol of the enduring power and glory of nursing. The torch has been passed on! May the deep, beautiful meaning of the lamp abide with them all the way.

Patients you have known

THE POST-OPERATIVE PRIMPER

Just because she's had her appendix out, she acts as if she's having a coming out party. And *you* feel like taking a powder every time *she* reaches for the powder, rouge, lipstick, etc.

Well, an easy way to bring a *natural* flush of pleasure to those cheeks is to tell her about delicious Instant Sanka Coffee. If the doctor has told her to keep away from caffein, she'll thrill to the news that she can still drink satisfying, full-bodied coffee—*caffein-free Instant Sanka Coffee.*

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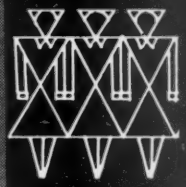

ADMINISTRATOR: Small hosp. currently under construction, need by July 1. NW mountain area. RN5-1 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ADMINISTRATIVE ASS'T IN NURSING SERVICE: For 225 bed special hospital. Advance preparation required. To assist with Nursing Service and Inservice Education Program for professional staff. Liberal personnel policies. Room available in attractive Nurses' Residence. Apply Director of Nursing, The Children's Memorial Hospital, 707 West Fullerton Ave., Chicago 14, Ill.

ANESTHETISTS: (a) Dir. School of Anes. $7500-$9000. (b) Nurse anes. work with 2 MD Anesthesiologists at 400 bed hosp, 5 days, $6000, MW. (c) Staff, well known progressive clinic, young group of 16, large metro. area, $6000 up. (d) 100 bed indus. hosp, serve on staff of 3, Atomic Energy Project, to $7200. (e) Part time for small hosp, hours may be arranged. $450 guaranteed min. Town of 60,000 near btfl mount. terrain, So. RN5-2 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ANESTHETISTS: A.A.N.A. member. 250 bed general hospital, salary open, automatic increases, laundry provided, 40 hr. week, no obstetrics, liberal vacation and personnel policies, Social Security. Sutter Hospital, Sacramento, Calif.

ASS'T DIRECTOR OF NURSING (EDUCATIONAL DIRECTOR): For 1352 bed psychiatric hospital located in metropolitan city, Central Indiana, with medical center and 3 universities accessible. No basic psychiatric nursing affiliation. Working toward a 4 mos. deferred psychiatric nursing educational program for graduate nurses. Desirable opportunity for well qualified applicant. Master's Degree preferred, will accept B.S. with experience. Salary range 4500-6420. Motel with attached garage available for total maintenance (quarters, subsistence and laundry) deduction of $25 per mo. Group insurance available. Public Employee's Retirement Fund plus Social Security benefits. Write State Psychiatric Nursing Consultant, 1315 West 10th St., Indianapolis 7, Ind.

ASS'T DIRECTOR OF NURSING SERVICE: For modern general hospital of 184 beds. Experience and degree preferred. Liberal personnel policies with other liberal employee benefits. Increments twice yearly. 8 hr day, 40 hr wk. Apply to Director of Nurses, William McKinley Memorial Hospital, Trenton, N.J.

ASS'T DIRECTOR NURSING (NURSING SERVICE): For 2293 bed psychiatric hospital located in North Central Indiana with University accessible. 6-yr old basic psychiatric nursing affiliation. Working toward a field experience in nursing administration and/or supervision for nurses in advanced university programs. Desirable opportunity for well qualified applicant. Master's Degree preferred, will accept B.S. with experience. Salary range $4500-$6420. Apartment available for total maintenance (quarters, subsistence and laundry) deduction of $25 per mo. Group insurance available. Public Employee's Retirement Fund plus Social Security benefits. Write State Psychiatric Nursing Consultant, 1315 West 10th St., Indianapolis 7, Ind.

ASS'T DIRECTOR NURSING SERVICE: Excellent opportunity for nurse with supervisory experience. Mid-west 350 bed hospital with advanced policies. Salary open depending on experience and ability. Apply Box SRH-1 c/o R.N. Magazine, Oradell, N. J.

ASS'T INSTRUCTOR IN NURSING ARTS: Fully accredited School of Nursing with student body of 175. Degree in Nursing Education not required but work toward degree is essential. Some teaching or supervisory experience required. Salary commensurate with qualifications and experience. Apply Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

CENTRAL SUPPLY SERVICE SUPERVISOR: 287 bed hospital, Westchester on L.I. Sound. Completely new modern dept., fully staffed. Immediate openings. Apply Director of Nursing, United Hospital, Boston Post Road, Port Chester, N. Y.

CLEVELAND OHIO JOB OPPORTUNITIES FOR REGISTERED NURSES: 398 bed nonsectarian general hospital with fully accredited school of nursing. Scholarship assistance for study at nearby Western Reserve University. Prepare now for promotion opportunities made available by our hospital expansion program. Liberal personnel policies. Living accommodations. For detailed information write Director of Nursing, Mount Sinai Hospital, 1800 East 105th St., Cleveland 6, Ohio.

CLINICAL INSTRUCTOR IN OBSTETRICS: Fully accredited School of Nursing with student body of 175. Degree in Nursing Education not required, but work toward degree is essential. Some teaching or supervisory experience required. Position available July 1st. Apply Director of Nursing, The Toledo Hospital, 6, Ohio.

CLINICAL INSTRUCTOR, MEDICAL-SURGICAL NURSING: For new 225 bed general hospital. Position available in August. School reopening in Sept. New, modern, air-conditioned educational building adjacent to hospital and nurses home. Salary commensurate with training and experience. Laundry of uniforms, 40 hr wk, Social Security, mo. vacation, 6 holidays, 14 days sick leave. Degree and experience preferred. Apply Personnel Director, Petersburg General Hospital, Petersburg, Va.

COLLEGE NURSE: Experienced RN, available September to live on campus girls' college, Westchester County, 35 miles New York City. Attractive terms. Apply Box 700, R.N. Magazine, Oradell, N.J.

DENVER COLORADO JOB OPPORTUNITIES: Staff nurses for 417 bed general hospital with school of nursing. Full or part time. Choice of working 5 or 5½ day week. Going salary for Rocky Mouutain Region, bonus for evening and night duty. Paid sick leave, vacations and holidays. Social Security benefits. Some housing available or we will assist you in finding living accommodations. Excellent opportunity for study at Denver University. Denver's climate is unsurpassed the year around. Opportunities for sports and entertainment are many. If interested wire collect for additional information or write Director of Nursing Service, St. Luke's Hospital, 601 East 19th Ave., Denver 3, Colo.

DIRECTOR OF NURSES: and Principal of the School of Nursing. Position available for experienced Nursing Administrator with degree to have full charge of Nursing Service and School of Nursing in 210 bed hospital with 100 students in the school. Located in Merrimack Valley, 30 mi. north of Boston. Modern equipment and facilities. Apply to Administrator, Lowell General Hospital, Lowell, Mass.

DIRECTOR OF NURSING EDUCATION & NURSING SERVICE: Masters Degree preferred but not required. 150 bed general hospital, student body of 36, salary open. For further information write Administrator, Columbia Memorial Hospital, Hudson, N.Y.

DIRECTORS OF NURSING: (a) Brand new 50 bed proprietary hosp, organize dept, hire personnel, ideal Calif. location. $5000-$6000. (b) Dir. Service & Educ, 250 bed gen hosp, well organized staff, 100 students, near leading E metro. city, $6000, mtce. (c) Asst. Dir. Nursing service, excellent executive opport, univ affil. 300 bed hosp, lake shore campus. (d) Nurse Consultant, investigate commercial nursing homes, determine eligibility for state approval. $6600, travel expenses. (e) Dir. 200 bed gen hosp, top flight adm. ability, progressive SW city 300,000, ideal climate, to $7200. (f) Dir. School & Service, 500 bed gen hosp, 200 students, congenial working conditions, leading MW industrial city, to $11,000. RN5-3 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

EVENING SUPERVISOR: Progressive School of Nursing in suburban Philadelphia. Liberal personnel policies include 14 days sick leave, 28 days vacation, 7 holidays annually. 40 hr 5 day wk. Social Security. One class annually. Degree required. Periodic increases. Salary commensurate with qualifications. Reply to Box GD-1 c/o R. N. Magazine, Oradell, N.J.

FACULTY POSTS: (a) Dir. of Basic Nursing Program, new dept. of well estab. univ. school of medicine, plan & coordinate all aspects, 350 bed hosp, So. (b) Med-Surg., OB, Ped, Tb, Psych, Nursing Arts Instructors, leading univ. hosp, 200 students, exc. opport. for growth, near key MW city. (c) Ed. Dir, OB Cl. Inst., well organized school of noted 400 bed hosp, int. cosmopolitan city outside US, $6000, $5000 respectively. (d) Ass't Inst. Med. Surg, NA Inst, 200 bed genl hosp, near NYC, $4200, $4650, respectively. RN4-5 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

GENERAL DUTY: 40 hr wk, 84 bed hospital, finest equipment, very liberal personnel poli-

cies and pleasant working environment. Must be willing to rotate shifts. Salary range $277 to $360 monthly. Atomic Energy Project but not Civil Service. Write Director of Nursing Service, Los Alamos Medical Center, Los Alamos, N.M.

GENERAL DUTY NURSES: 38 bed hospital. Prevailing salaries paid . $10 per mo. for evening and night shift, 40 hr wk. San Gorgonio Pass Memorial Hospital, Banning, Calif.

GENERAL DUTY NURSES: For 76 bed general hospital in university town. Prevailing salaries paid. Full maintenance available. Redlands Community Hospital, Redlands, Calif.

GENERAL DUTY NURSES: 120 bed hospital, southern Wyoming community of 12,000. Liberal personnel policies, 40 hr wk. Starting salary $263 with a charge of $23 for full maintenance. Additional $10 per mo. for evening and night duty with regular increases. Surgical Nurses starting salary $273 plus $5 per call after 5 p.m. Nurses' Home recently redecorated and refurnished. Write Director of Nurses, Memorial Hospital, Rock Springs, Wyo.

GENERAL DUTY NURSES: All shifts, all services. 466 bed hospital. Quarters available. Apply Director of Nurses, Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, Calif.

GENERAL DUTY NURSES: For a 40 bed hospital. Est. 1950, well equipped. Salary $1.50 per hr, 44 hr wk, salary increases at 12 mos, 2 wks annual paid vacation, meals furnished on duty. Attractive living quarters available, very reasonable. Apply Director of Personnel, Safford Inn Hospital, Inc., 625 Central Ave., Safford, Ariz.

GENERAL DUTY NURSES: 118 bed general hospital located in a beautiful residential section along the North Shore of Chicago. Starting salary $300 a month, bonus of $30 for evenings and $20 for nights. 40 hr. wk. Modern ranch style nurses' homes with attractively furnished private bedrooms. Contact Director of Nursing Service, Highland Park Hospital Foundation, Highland Park, Ill.

GENERAL DUTY NURSES: Salary $317-$347 mo, $25 eve., $15 night differential. Work in Chicago's outstanding 275 bed modern teaching hospital. Located on Northwestern University Lakefront campus. $3,000,000 expansion program. Modern, attractively furnished apartments. Most progressive benefit program in the field. Best qualified applicants accepted. If head nurse caliber, we have promotion plan for you. Apply Personnel Relations Dept., 303 East Superior, Chicago 11, Ill.

GENERAL DUTY NURSES: Wanted immediately for 44 bed general hospital located in Northeastern Ohio. Openings in all services. Salary depending on experience and ability, bonus for 3-11 and 11-7, 2 wks vacation after 1 yr employment, 7 legal holidays. Apply Director of Nurses, Lodi Hospital, Lodi, Ohio

GENERAL DUTY STAFF NURSE: New and modernized 300 bed general hospital offers top salaries and opportunities to advance. Evenings $76.80-$89.60 per wk, nights $73.60-$86.10, days $64.00-$75.60. Openings in Medical, Surgical, Obstetrics, Pediatrics, Operating Rooms and Emergency Room. 40 hr wk, merit increases, liberal policies. On

Long Island Sound, 45 mins to N.Y.C. Modern nurses residence and school. Apply Director of Nursing, Stamford Hospital, Stamford, Conn.

GENERAL DUTY AND SURGICAL NURSES: For 271 bed general hospital in residential suburb of Chicago. 40 hr wk. Cash salary and live in: $235 day duty, $245 pm duty, $250 night duty, plus private room in new nurses' residence, 3 meals per day and free laundry of uniforms. Cash salary and live out: $275 day duty, $285 pm duty, $290 night duty plus 1 meal and free laundry of uniforms. $15 differential for surgical nurses. Low rental apartments available for married nurses. Planned service increases for nurses: $10 after 60 days and at regular intervals. Many other benefits. Write Personnel Director, MacNeal Memorial Hospital, Berwyn, Ill.

GENERAL STAFF NURSES: For fully accredited private teaching hospital located on Lake Michigan just North of Chicago. 5 day 40 hr wk, salary range $303-$328.70. Shift bonus $26 afternoons and $17 nights. Progressive personnel policies. Excellent cafeteria and attractive rooms at reasonable rates. Please indicate type of service preferred. Apply Director of Nursing, Evanston Hospital, 2650 Ridge Ave., Evanston, Ill.

GENERAL STAFF NURSES: For 200 bed general hospital. Openings in Ped, O.B. & Med.-Surg. Minimum starting salary $255. 40 hr work wk, special consideration given for experience and qualifications. Merit increases at 6 mo, 12 mo and annually thereafter. Evening and night duty differential $10. Good personnel policies. Rooms available $20 per mo. Write Dir. of Nursing Service, Memorial Hospital, Casper, Wyo.

GENERAL STAFF NURSES: For pediatric nursing in 225 bed hospital. Salary $325 per mo for PM and night duty, $300 per mo for day duty. 40 hr wk, salary increments at end of 6, 12 and 24 mos based on merit. 3 wks annual pd vacation, uniform laundry, Social Security, group insurance, sick and accident benefits. Rooms available in attractive nurses' residence. Apply Director of Nursing, The Children's Memorial Hospital, 707 W. Fullerton Ave., Chicago 14, Ill.

GENERAL STAFF NURSES: Medicine, Surgery, Obstetrics, Nursery. Beginning salary $240 with increments every 6 mos for 5 yrs. 1 meal and laundry gratis. 340 bed general hospital, near two universities, 20 minutes New York City, excellent personnel policies, 40 hr wk, overtime pay, 3 wks vacation, 4 wks after 3 yrs, sick time cumulative to 60 days. Instaff educational program, Social Security, Blue Cross available, 8 paid holidays, pleasant working surroundings. Advanced preparation encouraged. Apply Director of Nursing Service, Presbyterian Hospital, Newark 7, N.J.

GENERAL STAFF NURSES: This is a friendly place to work in preferred dept. of 200 bed JCAH general hospital with an active building program. Liberal personnel policies include 40 hr wk, retirement plan, paid hospitalization insurance premium, accumulative 30 day sick leave, 2 wks vacation, 6 holidays annually, meals at cost, rooms at $20 per mo, 40 mins. from Detroit. Initial salary evenings $336.80-$371.47, nights $322.80-$357.47, days $306.80-$341.47. For details write Director of Nursing, Wyandotte General Hospital, Wyandotte, Mich.

GENERAL STAFF NURSES: 270 bed general hospital and 72 bed maternity hospital. Starting salary $305 a month. $5 month tenure increase for each 6 mos to maximum of $335. $25 additional for afternoon and night. $25 additional for surgery. Liberal paid annual vacation. 7 paid holidays, 8 hr day and 40 hr wk, Social Security and employer-paid health and life insurance program. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GRADUATE NURSES: For medical and surgical services, modern 263 bed mid-Manhattan hospital. 5 day, 40 hr wk. Starting salary $291, eves. $330, nights $320. Uniform laundry, 2 meals per tour. 4 annual increases, 4 wks vacation, 12 holidays, sick leave 12 days per yr. cumulative. Soc. Sec., health service, free hospitalization. Opportunities for special assignments, research nursing bonuses and postgrad. study. Housing agent available. Apply Supt. of Nurses, James Ewing Hospital, 1250 First Ave., New York 21, N.Y.

GRADUATE NURSES: For general duty in 135 bed general hospital. No school, organized medical staff, high quality service, pleasant surroundings, attractive living conditions in nurses' home, good pay. For information write Director of Nursing, John D. Archbold Memorial Hospital, Thomasville, Ga.

GRADUATE NURSES: Positions for those who either have or are willing to obtain Colorado registry. Floor duty, rotating shifts, uniform laundry and meals furnished, 2 weeks paid vacation and 7 days sick leave per year. 35 bed hospital in a growing community. Southwest Memorial Hospital, Cortez, Colo.

GRADUATE NURSES: Immediate employment in the expanding institutional program of the State of Kansas. Openings in training schools for mentally retarded children and in tuberculosis and psychiatric hospitals ranging in size from 350 to 1700 beds. Beginning salaries range from $267 to $415 per mo. Can advance to $530 per mo in supervisory capacity. Maintenance is usually available at a nominal fee. Must be eligible for registration in Kansas. Contact Miss Carmelita F. Craven, Nursing Consultant, Division of Institutional Management, State Dept. of Social Welfare, 801 Harrison St., Topeka, Kans., or Personnel Division, Dept. of Administration, 801 Harrison St., Topeka, Kans.

GRADUATE NURSES: For general duty, all shifts, 75 bed general hospital, new, air-conditioned with modern equipment. Good personnel policies, vacation, sick leave, paid holiday time. Located in beautiful Central Florida. Apply Director of Nurses, Seminole Memorial Hospital, Sanford, Fla.

GRADUATE NURSES & ASS'T HEAD NURSES: We are not partial to any one of the many fine new automobiles coming off the assembly lines but we do like the slogan of one—"The Forward Look". As a matter of fact, the slogan could apply very well to the Los Angeles County Hospital System. Maybe that's why we like it. We have a superior physical plant—buildings, equipment, facilities—that is tops now, but it is steadily being improved. Just this year a new 200 bed Communicable Disease Building was dedicated. Last year a new Psychiatric Building was dedicated. A new $350,000 Student Nurses Home is in process. Thousands of dollars on new

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equipments are added each year. But even more important than buildings and equipments is our modern approach to our patients and our nurses. At our hospitals nurses are important people. They receive good pay, Civil Service protection in their jobs, opportunities for advancement and opportunities to learn. There is constant attention to making things better for the nurse, the doctor, the patient. (Several new Nurse Instructors were employed just this year to assist in improvement of patient care and planning and carrying out an organized educational program for all Nursing Service personnel.) That forward look just creeps into everything. Los Angeles is growing rapidly—18,340 new settlers each month. They keep coming because Los Angeles is a wonderful place to live and work. It's a booming, vital city—a city with a forward look. A city for forward-looking nurses. The Los Angeles County Hospital System consists of 6 separate hospitals: A TB hospital in San Fernando Valley and in Long Beach; an 800 bed general hospital in Torrance (one mile from the Pacific Ocean); Rancho Los Amigos containing the largest Polio Center west of the Mississippi; the 200 bed John Wesley County Hospital—a recent acquisition; and the County General Hospital, just about the largest hospital in the world. We have a fine School of Nursing, too. If you care to suggest our school to prospective nurses, we should appreciate it Beginning salary for our nurses is $288 and $319 for Ass't Head Nurses. In addition, there are bonuses for evening and night duty and Communicable Diseases, Psychiatric and TB nursing. All of our nurses do the professional job they were trained to do. Why not write us for further information. Write J. K. McInnis, R.N., Los Angeles County General Hospital, Box 1311, Los Angeles 33, Calif. You won't be sorry that you did.

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HIGH CALIBER REGISTERED NURSES: We need good nurses interested both in latest scientific therapy and old-fashioned warm care of patients with cancer and allied diseases. Teaching and research center offers valuable experience. Adequate staff of top nurses maintained. University-affiliated inservice education, access all NYC university programs. Good basic preparation required, learn specialty here. Staff Nurses, $280-320 Day; $330-370 Eve; $320-360 Nite. 4 wks vacation, 1½ pay for overtime, uniforms laundered, Blue Cross paid by Center. Minimum rotation. Suture nurses, base salary plus ½ pay for on-call hrs. Housing agent helps you locate. Thelma Laird, R.N., Director of Nursing, Memorial Center, 444 E. 68th St., New York 21, N.Y.

INDUSTRIAL, OFFICE: (a) Office, nurse, good opport. for capable person, 5 days, to $350, SW. (b) Ind. clinic nurse, travel with medical trailer thru So, congenial staff. RN5-5 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

IN-SERVICE EDUCATION SUPERVISOR: To collaborate with ass't director in charge nursing service in re-organizing in-service educational program for all categories. B.S. Degree and satisfactory experience in teaching and/or supervision. Salary commensurate with education and experience. 500 bed voluntary hospital. Liberal personnel policies. Comfortable living quarters available at low cost. Easy accessibility to New York City and universities. Write to Director of Nursing, Newark Beth Israel Hospital, 201 Lyons Ave., Newark 12, N.J.

INSTRUCTOR: Nursing Arts. For complete information write Tulare-Kings Counties Hospital, Springville, Calif.

INSTRUCTOR—MEDICAL & SURGICAL NURSING: Degree required, immediate opening. Salary dependent upon preparation and experience. Admit only one class a year. 90 students in the School. Excellent personnel policies including 40 hr wk, all cash salary. Social Security and retirement plan. Apply Director of Nursing, Mercer Hospital, Trenton, N.J.

INSTRUCTOR-MEDICAL & SURGICAL NURSING: Progressive School of Nursing in suburban Philadelphia. Liberal personnel policies include 14 days sick leave, 28 days vacation, 7 holidays annually. 40 hr 5 day wk. Social Security. One class annually. Degree required. Periodic increases. Salary commensurate with qualifications. Reply to Box GD-3 c/o R.N. Magazine, Oradell, N.J.

LABORATORY TECHNICIAN: Registered, experienced or recent graduate of qualified hospital. Excellent salary, 40 hr wk, 8 hr day. General hospital, 200 bed. P.O. Box 840, Battle Creek, Mich.

MEDICAL CLINICAL INSTRUCTOR: Opening available July '56. Liberal personnel policies, 40 hr wk, 28 days vacation, 8 pd holidays, 18 mi from New York City. Live in if desired. (New ultra-modern 350 bed hospital will be completed in April 1957). Apply Director of Nurses, Clara Maass Memorial Hospital, 12th Ave. & Newton St., Newark, N.J.

[Turn the page]

NURSE ANESTHETIST: Openings available now. Salary range $4050-$5170. 1000 bed public general, teaching hospital. Write Superintendent, Edward J. Meyer Memorial Hospital, 462 Grider St., Buffalo 15, N.Y.

NURSE ANESTHETIST, REGISTERED: Experienced or recent graduate of a qualified school, excellent salary, 40 hr wk, 8 hr day. General hospital, 200 bed. Phone collect WO 2-8551 or write P.O. Box 840, Battle Creek, Mich.

NURSES: Modern 200 bed, fully accredited hosp. in beautiful Cumberland Valley college town, has openings in General Duty (Medical and Surgery), Operating Room, Pediatrics, Maternity and Nursery. Friendly, informal atmosphere. 40 hr wk, 7 pd. holidays. Free hospitalization, Social Security. 2 wks vacation after 1 yr, other benefits. Apply Dorothy D. Bollinger, R.N., Director of Nursing, Chambersgburg Hospital, Chambersburg, Pa.

NURSES: Openings for staff and ass't head nurses in medical, surgical and pediatric units in new University of Oregon Medical School Hospital, Portland, Oregon. Opportunities on campus for furthering education in nursing. Write to Director of Nursing Service for full information.

NURSES: General hospital, 236 beds, new building, modern equipment. 30 miles from New York City. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

NURSES: Top salary. Openings on research wards in a well-known N.Y. hospital for graduate nurses with N.Y. State License. Staff nurses, $316.66 per mo; Ass't head nurses, $340 per mo; Supervisors, $416.66 per mo. All required to rotate shifts when necessary. $50 monthly supplement for evening duty, $40 monthly supplement for night duty (no monthly supplement for supervisors). Please submit complete resume of training and experience to Dr. Joseph H. Burchenal, c /o Sloan-Kettering Institute, 410 E. 68th st., New York, N.Y.

NURSES: General Duty, for 30 bed hospital 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

NURSES: Positions available for R.N.'s under age 50. Beginning salary $310 per mo. $5 longevity increase every 6 mos for 3 yrs. Retirement plan, sick leave benefits, 11 holidays, 3 wks vacation, 40 hr wk. New modern residence. State eligibility for California registration and submit photo to Director of Nurses, Tulare-Kings Counties Hospital, Springville, Calif.

NURSES-MEN & WOMEN-GENERAL STAFF: 40 hr wk, 8 hr day, rotating day, evening and night duty. Salary $282 per mo, plus laundering of uniforms, meals on duty, inside maintenance optional with suitable deductions. $20 per mo additional for evening duty, $15 per mo additional for night duty, $20 per mo additional for tuberculosis, psychiatric and contagion duty, $180 yearly increment, liberal sick leave, vacation, 10 holidays, pension plan, advancement opportunities. Pleasant Westchester County suburban rural environment, easily accessible New York City. Write or telephone Director of Nursing, Grasslands Hospital, Valhalla, N.Y. LYric 2-8500.

NURSES: PROFESSIONAL: 1. Medicine, surgery, pediatrics obstetrics, 2. Delivery room, evenings and nights, 3. Team leader (Ass't night supervisor). Experience recognized. Salary open. Director of Nurses, Saint Barnabas Hospital, 685 High St., Newark, N.J.

NURSES-STAFF: For 235 bed modern hospital near Nation's Capital, 5 day 40 hr wk, hospitalization insurance and one meal per day furnished by hospital, annual and sick leave after 6 mos employment, longevity and merit increases. Beginning salary $2880 per yr. Differential paid for straight evening and night shifts and for delivery rooms. Write Director of Nurses, Prince George's General Hospital, Cheverly, Md.

NURSING ARTS INSTRUCTOR: For new 225 bed general hospital. Position available in August. School reopening in Sept. Salary commensurate with training and experience. Laundry of uniforms, 40 hr wk, Social Security, mo. vacation, 6 holidays, 14 days sick leave. Degree and experience preferred. Apply Personnel Director, Petersburg General Hospital, Petersburg, Va.

NURSING ARTS INSTRUCTOR: Opening available August '56. Salary commensurate with education and experience. 40 hr wk, 28 days vacation, 8 pd holidays. 18 mi from New York City. Live in if desired. (New ultra-modern 350 bed hospital will be completed in

April 1957). Apply Director of Nurses, Clara Maass Memorial Hospital, 12th Ave. & Newton St., Newark, N.J.

NURSING ARTS INSTRUCTOR: Progressive School of Nursing in suburban Philadelphia. Liberal personnel policies include 14 days sick leave, 28 days vacation, 7 holidays annually. 40 hr, 5 day wk. Social Security. One class annually. Degree required. Periodic increases. Salary commensurate with qualifications. Reply to Box GD-2 c/o R.N. Magazine, Oradell, N.J.

OBSTETRIC & PEDIATRIC SUPERVISORS: For new 225 bed general hospital. Combined teaching and supervisory duties. School reopening. Salary commensurate with training and experience, laundry of uniforms, 40 hr wk, Social Security, 1 mo vacation, 6 holidays, 14 days sick leave. Apply Personnel Director, Petersburg General Hospital, Petersburg. Va.

OBSTETRICAL NURSES: Openings for Supervisor, Asst Supervisor. Immediate need for staff in 30 bed unit, averaging 100 deliveries per mo. Starting salary $255 with 6 mo and 1 yr merit increases, yearly thereafter. Special considerations given for experience and qualifications. $10 differential for 3-11 and 11-7. Good personnel policies, rooms available $20 per mo. Write Director Nursing Service, Memorial Hospital, Casper, Wyo.

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REGISTERED NURSES: Staff and O.R. 25 bed general hospital, West Texas Community, population 5000. Starting salary $275. Additional for O.R. calls. 40 hr 5 day wk. 2 wks pd vacation after 1 yr. Maintenance in nurses home for $15 per mo. Apply Supt. of Nurses, Memorial Hospital, Fort Stockton, Tex.

REGISTERED NURSES: Near the Ski Capital of the East. Gen. duty and OR. 40 hr wk, liberal vacations, sick leave, holidays, other benefits. Write Administrator, Kerbs Memorial Hospital, St. Albans, Vt.

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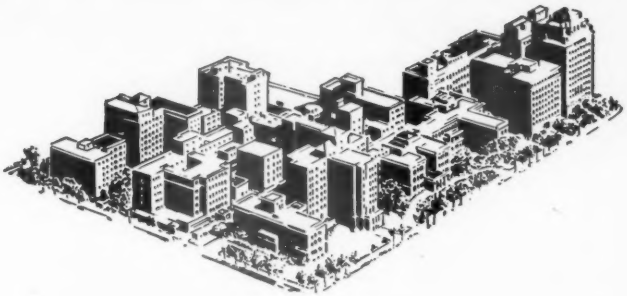

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REGISTERED NURSES: For Veterans Administration Hospital, McKinney, Texas, located 30 mi north of downtown Dallas on U.S. Highway 75. 500 bed general medical and surgical hospital affiliated with the University of Texas, Southwestern Medical School in residency training. Included is a 130 bed Tuberculosis Service. Minimum annual salary $4025 with yearly increases. Other salaries dependent upon professional qualifications. Personnel policies provide 40 hr wk, 30 days vacation leave and 15 days sick leave accrual per yr in addition to 8 established holidays. Federal retirement system coverage. Federal Group Employees Life Insurance plan and Blue Cross Hospitalization available. $53 annual uniform allowance and free uniform laundry. Non-housekeeping quarters. 9 hole golf course and swimming pool on hospital grounds. U. S. Citizenship required. Contact Chief, Nursing Service, V. A. Hospital, McKinney, Tex.

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REGISTERED NURSES: New 40 bed hospital, Texas Vacation Land, near large cities. Excellent salary and personnel policies. Floor duty and surgery. Write Administrator, New Braunfels Hospital, Inc., New Braunfels, Tex.

REGISTERED NURSES: In progressive 250 bed fully approved hospital located in beautiful, exciting western city with ideal climate, mild winters. 5 day week, 40 hrs., starting salary $265 with automatic increase every

6 mos., of $100 per year, or $8.33 per mo. up to three years. $10 per mo. differential paid to those working afternoon and night shifts. Minimum wage scale for surgery nurses is $275. Write Superintendent of Nurses, Washoe Medical Center, Reno, Nev.

REGISTERED NURSES: For staff nurse positions, U.C.L.A. Teaching Hospital. 40 hr wk, 3 wks vacation, sick leave benefits, good promotional opportunities. Apply University of California Employment Office. 10833 LeConte Ave., Los Angeles 24, Calif. BRadshaw 28911, GRanite 89711, Ext. 344.

REGISTERED NURSES: For 200 bed tuberculosis sanatorium. Starting salary $290 to $325 per mo depending on qualifications and experience. Maintenance available at minimum rate. Annual leave, sick leave and 10 holidays. Medical Director, New Mexico State Tuberculosis Sanatorium, Box SS, Socorro, N.M.

REGISTERED NURSES: 28 bed company owned hospital, immediate vacancy for operating room-clinic nurse. Openings for general duty. Salary $16.38 and $15.23 per day respectively, including complete maintenance. 5 day, 40 hr wk. Pd vacations, Social Security, etc. Apply Dorothy M. Haman, Supt., Steptoe Valley Hospital, East Ely, Nev.

REGISTERED NURSES: For General Duty and Obstetrics. 65 bed general hospital, 30 mi from Chicago on Lake Michigan. Well-equipped Nurses' Home, single rooms. Starting salary $300 with increases. Rotating shifts or permanent eve or night duty with generous bonus. Apply Director of Nurses, Lake Forest Hospital, Lake Forest, Ill.

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SPECIAL NOTICE TO REGISTERED NURSES: A mature registered nurse to assist in the management of a 50 bed nursing home, bus connection to New York at door, 25 mi. away. Live-in requirement, salary excellent, opportunity unlimited. References and personal interview required. Do not answer this ad unless your references are excellent as they will be searched. Apply Box MVH-1 c/o R.N. Magazine, Oradell, N.J.

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STAFF NURSES: Wide clinical experience. 40 hr wk, starting salary $300 mo. Please write to Dept. of Nursing for further details, University Hospital, Ann Arbor, Mich.

STAFF NURSES: For 75 bed hospital. 40 hr wk, starting salary $250. Good personnel policies. Hamilton County Public Hospital, Webster City, Iowa.

STAFF NURSES: For 225 bed Southern California hospital on coast. Attractive personnel policies including 40 hr wk. Salary for California registered nurses starts at $265 and increases on merit rating. Apply Director of Nursing, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

STAFF NURSES: For Central California modern community of approximately 60,000. 400 bed county general hospital. Commuting distance to mountain resort areas or San Francisco, 3-11 and 11-7 shifts, 40 hr wk, 3 wks pd vacation at end of 1st yr, 11 holidays a year and sick time accumulative to 50 days. Retirement system. Group insurance available. Rooms in Nurses' Home at $15 per mo. Starting salary $290 plus $10 bonus for pm and night shifts. Write Director of Nurses, Stanislaus County Hospital, 830 Scenic Drive, Modesto, Calif.

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STAFF NURSES-OPERATING ROOM NURSES: For modern 650 bed tuberculosis hosp. affiliated with Western Reserve University and approved by joint commission on accreditation of hospitals. 40 hr wk, 5 day week. Salary $293 to $323, with automatic increases. Full maintenance available at minimum rate. Housing for two or more nurses. Advancement for eligible applicants. Meets approved minimum employment standards of the State Nurses' Association. Apply to Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio

STAFF NURSING: Annually $3670, 40 hr wk. University and in-service opportunities. For personnel policies, blanks, write Director of Nursing, D.C., General Hospital, Washington 3, D.C.

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SUPERVISOR: 3-11 PM, 332 bed general hospital with School of Nursing, degree and experience desired. 40 hr wk, liberal personnel policies, living accommodations available, salary commensurate with qualifications, position available immediately. Apply Director of Nursing, Toledo Hospital, Toledo 6, Ohio

SUPERVISORS: (a) Med.-Surg. Comm. Dis, OB, 300 bed modern hosp, Amer. owned foreign location, $8500-$9200. (b) Floor or specialty, interested directing small hosp, nursing dept, metro resort areas, to $5000. (c) OB, 300 bed hosp. unit of 45, 1600 births annually, btfl college town, MW to $6000. (d) OR, modern 100 bed hosp, wealthy Tex. oil town, mtce. provided. (e) Emergency Room, also relieve nursing service office, 150 bed hosp expanding to 400, ideal Fla. winter resort. RN5-9 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

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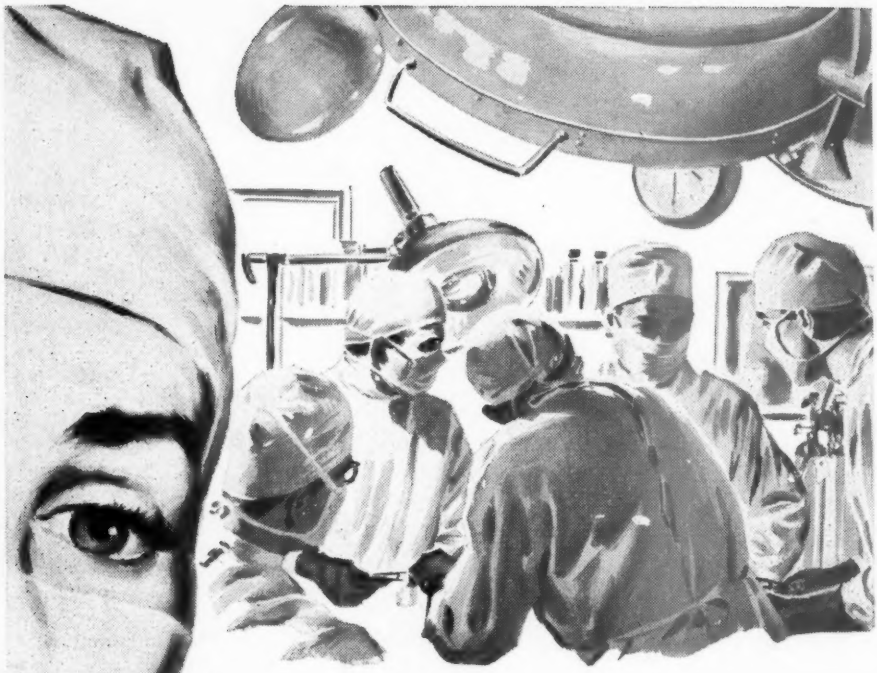

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